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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on Delayed Union and Non-union of Bones.* By GEO. W. CALLENDER, F.R.S., Surgeon to St. Bartholomew's Hospital.

Amongst the cases in Harly Ward, gentlemen, is that of a man aged 43, who has broken his right leg; and, although it is true that, in the great majority of instances, our fractures are easily managed throughout their repair, yet, as in the present case, it occasionally happens that we have anxiety as to the result, or are obliged even to be content with a repair which is faulty either as regards the lock or as regards the utility of the limb. I may have an opportunity for showing to you, by some cases in point, how we are sometimes unable to prevent the latter unfavorable ending. I now, however, propose to tell you of the trouble which occurred in the case to which I have referred, to give you its explanation, and to point out some common causes of delay in the union of bones, which, if not counteracted, furnish the greater number of cases of so-called non-union of fracture.

This man fell into a well, and, striking his right leg against a piece of timber in his fall, was brought to the hospital with a transverse fracture of the tibia and fibula—a fracture caused, you will observe, by direct violence. The injured limb was placed on a back-splint, and swung in the ordinary way; and, fourteen days later, the apparatus was readjusted. It was not, however, until the expiration of thirteen weeks that the bones united, and then not firmly; so that his leaving the ward has been delayed until the present time, nearly sixteen weeks after the accident happened; whilst, as most of you are aware, five or six weeks, in an ordinary case, would have sufficed for the cure.

Soon after this man's admission, we noticed that the limb was becoming œdema-

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tous; and this œdema persisted, increasing the size of the leg, with a firm and dense hardness of its tissues, for nearly all the time during which union of the fracture was so slowly progressing. This œdema indicated, as it always does in these cases, obstruction of some large venous trunk. The violence which breaks the bones of a limb, especially when applied directly, causes bruising of the soft parts about the fracture, as shown in an ordinary way by the ecchymosis of the tissues; and if, as sometimes happens, a considerable vein be torn, or flattened by the pressure against it of displaced bone, we find that its canal becomes obstructed by a clot of blood both above and below the seat of injury, and in this way circulation through the vessel is arrested. We frequently have opportunities of seeing this condition of the veins in cases of severe fracture which terminate fatally; and in the *System of Surgery* I have referred to several *post-mortem* examinations in which this obstruction of the veins was shown to have existed. When a great vein is thus closed, the balance between the arterial and venous vessels in the limb is so disturbed that, whilst the usual arterial supply continues, the veins which are left unhurt are unequal to carry off the venous blood; and thus there follows after a while that ordinary relief of the over-distended veins by which the œdema of the extremity is established, and during the continuance of which the repair of the fracture is sure to be slow, if, indeed, it make any progress at all. When, then, you see this state of things—an œdema beginning and persisting after a fracture—you may be sure your patient will make a very slow recovery from the injury.

I refer you to the remarks I have made elsewhere (*System of Surgery*, vol. iii., p. 366) for an explanation of the manner in which the clot is, by degrees, so altered in its character as to allow the reopening of the vein. Either it, the clot, shrinks to one side of the vessel—that to which it is most firmly held by the secondary clots extending into collateral branches; or it is slowly tunnelled through by the action of the blood-stream. With either, the subsidence of the œdema marks the completion of the process, and more rapid repair of the fracture ensues. And let me add that this is the usual way in which the circulation rights itself; for, in these cases of occlusion of large veins with fracture, the obstruction is not compensated for by any change in, such as dilatation of, the other veins of the limb, although these vessels may have been unhurt at the time of the accident.

Such is the explanation of delayed union in not a few cases; and in such cases, knowing the cause, and the attendant symptoms being well marked, you will be prepared to allow an unusual length of time to elapse before you will expect firm union of the bones. Even after union has taken place, it is especially necessary to guard these fractures, as the patient first begins to move about, with the gum-and-starch bandages, of which, let me add, you will find the use far preferable to that of the plaster of Paris, of which patients complain as heavy and uncomfortable.

It is surprising how long union is delayed in some cases. I have known it deferred, in the case of a woman whose thigh-bone was broken, for ten months; her history was told by Mr. Whitmore at the Abernethian Society last session. In the case of a soldier, the humerus was two years and a half before it united; and in Mr. Stanley's case—the one in which he first inserted ivory pegs—two years elapsed before the femur was repaired. Now, in any of these cases, if treatment had not been persevered with, the delayed union would have drifted into the state known as that of non-union—a trouble which we should seldom witness if the causes of delayed union were more closely examined, and time allowed for, or treatment adapted to, the wants of each case. As it is, non-union of a fracture is a rare occurrence. Lonsdale, Hamilton, and others with large experience, have rarely met with such cases in their own practice. Here, in our wards, I find there has been but one case in two thousand five hundred fractures, excepting, of course, certain fractures, such as the transverse of the patella, to which I will presently refer; so that, the occurrence being so rare, it is, in my opinion, quite needless to seek for its explana-

tion in the constitutional conditions you will find enumerated in surgical works. Age, pregnancy, debility, paralysis, may be dismissed from consideration; and, as to the influence of syphilis, you have only to visit any one of our accident wards, and you will find evidence enough to prove that it is no obstacle to the repair of fractures. Nor has the seat of the injury, including the relation to the nutrient vessel, anything to do with the non-union of the broken bone (with the exceptions I will presently name); although the delay in union may be thus explained, and great care in the treatment may be thus in some cases called for.

It must be admitted, however, that some conditions, chiefly of a local character, absolutely prevent a broken bone from being mended. Such fractures as result from cancerous infiltration of bone are practically irremediable; so also are those which involve a bone atrophied from disease. There was an instance of this some four years ago in the hospital wards, in the case of a man who had the lower end of the femur hollowed out into a large abscess-like cavity, the wall of which, thin as parchment, had cracked across at the condyles, and would not repair. Then, again, there are cases in which foreign bodies interpose between the fractured ends, of which Sir James Earle's case of a portion of deltoid muscle getting between the broken pieces of a humerus, and the occasional wedging of a piece of broken and subsequently necrosed bone between the fractured ends, are instances; and, lastly, other cases in which it is difficult, sometimes impossible, to keep the broken portions in apposition, as in some cases of fracture at the neck of the thigh-bone, and in most instances of transverse fracture of the patella, which is an injury almost invariably repaired by fibrous tissue. But, if we allow for these cases, we have remaining some instances of non-union which do not admit of explanation on such local grounds, and which are generally referred after a time to air, to age, sometimes to youth, or to some of those constitutional conditions which I have ventured to tell you cannot be credited with the occurrence of non-union; although one, perhaps—namely, debility—may be responsible for delayed repair. From such cases, a certain number may be deducted which, without question, have been badly treated by inexperienced or untutored persons—fractures occurring on board ship, and the like; and then, of those which remain, it is within my experience that they are examples either of delay in the process of repair, as from the obstruction of veins, or of delay through the interposition of certain mechanical difficulties; and in these cases a favourable result may be generally obtained by treatment. For convenience in mentioning them, these latter may be referred to as fractures with certain displacements of bone, fractures extending obliquely through bone, and fractures in the vicinity of, not extending into, joints; and in each of these delayed union may be traced to the fact that sufficient time has not been allowed in the first instance for the firm union of the bones; for in each a longer time is needed than is thought necessary in the case of other, or, as they may be termed, ordinary fractures.

The fractures with displacement may be illustrated by an example taken from the femur. Quite recently, a youth has been under treatment in my wards with a fracture of the femur, which had been treated on board ship, and which had united very slowly, with shortening and a considerable bend outwards of the shaft of the bone. The patient was himself conscious of the weakness, as he called it, of the limb, when he first began to move about; and he was aware that the bending of the bone had increased at this time, which was before his admission here. In fact, the union, which might have been sufficiently good to support the weight of the body if the two parts of the femur had united so as to preserve the proper axis of the limb, and to allow the shaft to bear naturally the pressure from above, was insufficiently firm to resist the same pressure when brought to bear upon a shaft in which the fracture was joined at an angle; and the uniting tissue, under these circumstances, yielded, and in time, it is not unlikely, had he persisted in moving about, would have given way altogether, and we should have had a case of what would be

termed delayed union. It would have been said that the patient had moved about before the union was firm; or that, from some cause or other, firm union had been delayed; whereas the union was probably as good as in ordinary cases suffices to support the body, but in this instance was overstrained by the weight pressing at an angle instead of in the proper long axis of the thigh-bone. This case, then, represents a class in which longer time should be given for the consolidation of the repair than is needed when the long axis of the shaft can be properly preserved during the progress of union.

It is a somewhat similar condition which exists in cases of oblique fracture. The tibia—the bone of the leg which sustains the weight of the body—is often fractured so that two very oblique surfaces are left in contact. These specimens from the museum are examples of this injury. When such a hurt has to be treated, I always allow an extra fortnight—say six weeks in all—before the apparatus is disturbed and the patient allowed to put his foot to the ground; and for this reason: In these fractures, the whole weight of the man falls on and strains the new material, which has joined the fracture, in such a fashion that there is always a tendency for the upper fragment to glide off, or to be launched, as it were, from the lower: the latter part of the bone giving little if any support, whilst in a transverse fracture, or a fracture only slightly oblique, it largely assists in bearing the superincumbent weight. Imperceptibly, it may be, in such a case, the union gives way; pain is felt by the patient; and, on re-examining the limb, repair is found to be incomplete. All the cases of non-union of the bones of the leg which have been brought under my notice have been instances of oblique fracture; and every now and then, in these wards, we have found it necessary to put up afresh a fracture of this kind, upon which a patient has been allowed too soon to bear his weight.

Of fractures near the joint, that of the humerus in its lower third is, perhaps, of all the one most often followed by non-union. Various explanations have been offered with reference to this particular failure of bony union; but certainly in one case we could trace it to this, and I suspect, in most cases, it is in this direction that the cause is to be looked for. A fracture of the humerus is put up; and the forearm, at least for convenience, is placed at a right angle, and slung. As the case progresses, a question is raised as to the possibility of the elbow being stiff. The hand and forearm are flexed and extended a little, and the joint is said to move freely. If this examination be repeated, you must not be surprised if you find, when in due course you come to examine the fracture, that it has not united. The elbow being for the time somewhat stiff from disuse, it was not the joint which moved, but the fracture which was rocked in flexion and extension, as it easily may be when you act on it with the great leverage given you by the forearm, and so was hindered from becoming firm. I never knew an elbow-joint to be anything but temporarily stiff after a fracture of the humerus not extending into the joint; so that in these cases there is no excuse for handling the forearm. The arm should be left perfectly at rest during the entire process of repair; and no movement of the elbow should be permitted until it is certain that the bone is firm.

If you remember these as typical of certain classes of cases, you will be prepared to prevent the occurrence of non-union in most of the comparatively few cases in which special care will be called for. Of another class—that of failure of bony union from the difficulty of keeping the separate fragments in juxtaposition, as after transverse fracture of the patella—you may learn from this patient, recently discharged from Harley Ward, who has sustained an injury of this nature, that it it is not impossible to obtain osseous union even under what at first may appear unfavourable circumstances, if only you give time for the process to complete itself, and take care that in the meanwhile no strain is allowed to stretch the fibrous tissue which at first unites the pieces of the broken bone.—*Brit. Med. Journ.*, Nov. 30, 1872.

HOSPITAL NOTES AND GLEANINGS.

*Medullary Cancer cured by the Arsenical Mucilage Treatment.*—The following is a good example of the kind of cases for which the arsenical mucilage treatment, introduced by Dr. MARSDEN, Surgeon to the Cancer Hospital, is most preferred. The tumour being a medullary cancer of comparatively small size, situated on the exterior of the body, and not penetrating deeply into the tissues at its base, all the conditions as to nature, size, situation, and connections, combined to favour the use of the remedy, and the result was as successful as could be desired.

The tumour grew from the skin over the trapezius muscle near its anterior edge, about midway between the head and shoulder. It was quite circular at its base, with a diameter of nearly an inch, and rose about three-quarters of an inch above the level of the skin at its highest point in the centre—closely resembling, in fact, a large strawberry in size and shape, as well as in colour, the whole surface having a red fleshy appearance, cut up by fissures of various depths, and thickly covered by large round granulations. It was so closely encircled by skin, that it overlapped a little at the edges; the skin, however, around the base was not otherwise perceptibly altered except in colour, there being here simply an areola two or three lines in breadth, of a purplish hue, in the direction of which the veins were visibly increased and enlarged. It bled on the slightest touch, and, being extremely sensitive, was the source of constant pain. The history of the case showed that, about three years before, a small tumour appeared at the site of the present one, and, on being lanced, discharged blood freely. It continued to bleed more or less occasionally until the wound closed, when, in consequence of its increase and the pain arising from it, it was excised; soon afterwards it reformed, and was again excised, but still kept on growing; and, at the time of the patient's admission into the hospital, on February 22, 1872, presented the characters described. The patient was a moderately healthy woman, 42 years of age.

As the patient was in tolerably good health, there was no occasion for delay on that ground; and accordingly, on February 23, the arsenical paste (consisting of arsenious acid and mucilage of acacia, in the proportion of two drachms of the acid to one drachm of the mucilage, made into a thick paste) was laid over the whole surface of the tumour, and covered with cuttings of lint in the usual way. In three days, the diseased mass was quite movable, and a sulcus lay between it and the skin, leaving it attached only at a small portion of the base. Bread-and-water poultices were then applied and changed every three or four hours; and on the fourth day (February 27) the whole mass came away in a lump, leaving in place of the tumour a conical cavity with slightly indurated edges. The wound was poulticed in the same way as before for a few days, and then dressed with weak spirit lotion. Healthy granulations sprung up over the whole surface of the cavity, and by the 23d of March its size was reduced to about a third, and the induration of the edges was much less. On April 9, the wound was quite healed, the induration had entirely disappeared, and the only indication of the former disease left was the cicatrix and an increased vascularity of the skin around it. The patient remains quite well up to the present date (October 8).

Another case with a tumour, as near as possible in resemblance to the above, situated on the chest near the middle line immediately above the breast, is at present in the hospital under the care of Mr. Porter, for which the same method of treatment is being employed. This patient is a feeble old woman, 70 years of age, and has had the paste twice applied; the first application, although it appeared to remove the whole of the disease, being followed by a slight return of the growth when the wound was nearly healed. It is now, after the second application, progressing favourably, without any symptom of a return of the disease. Dr. Crombie, the house surgeon, remarks

that, during his residence at the hospital, he has seen other cases of recovery by this treatment continuing well at considerable intervals afterwards, although in one instance the disease removed from the cheek had appeared on the tongue about three years afterwards. — *Brit. Med. Journal*, Nov. 2, 1872.

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*Fracture of the Skull in Broca's Region; Paralysis of the Right Side; Loss of Power of Speech; Death; Autopsy.* — Although no single explanation seems sufficient to account for all cases of aphasia, still it must be granted that in the vast majority of the permanent cases there is paralysis of the right side, which is associated with some disease or injury of the posterior part of the third left frontal convolution of the brain. That this does not always obtain is fully proved by cases recorded by Vulpian, Charcot, and even Broca himself, in which there was aphasia but no disease of this portion of the brain, or disease of this part and no aphasia. Further, Trousseau gives a case in which there was well-marked aphasia with left hemiplegia. Nevertheless the following case is of interest, as showing a direct injury to this part of the brain followed by complete aphasia and subsequent paralysis of the right side. It is doubtful, however, whether the large effusion of blood was directly due to the injury, or took place secondarily from an injured or diseased vessel. It is difficult to believe that so extensive a destruction of brain-substance by the extravasated blood should not declare itself by paralysis of the right side till so many hours had elapsed. It is probable that the injury gave rise in the first instance to only a slight effusion of blood, but that this gradually increased till it assumed the dimensions found at the autopsy.

J. H——, a workman employed at the London Hospital, in a quarrel with one of his fellows, was struck on the left temple with the leg of an iron bedstead at about 5 P.M. The case was supposed to be one of scalp wound, and the patient was allowed to go home. It was not ascertained at this time that there was any affection of the speech. About three hours after the accident he was seen walking to his home, a distance of two miles from the hospital. On reaching home his wife, alarmed at the sight of the bandages, asked him what had happened, but, being unable to speak, he made signs for a pencil and paper. Before getting these he touched his head with his left hand (he was a left-handed man), pointed to the leg of a bedstead, and then clenched his hand as if striking a blow, which an intelligent neighbour interpreted to mean that he had received a blow on the head with the leg of a bedstead, to which he nodded assent. He then went to bed, using both his hands in undressing. A medical man being called in, it was directed that he should be brought to the hospital. To this the patient agreed, but in dressing it was noticed that he could not use his right hand, and, in walking to the cab, that he dragged his right foot. On arriving at the hospital he was quite insensible. Mr. McCarthy was then sent for, and saw him for the first time at 11 P.M., when he was unconscious and breathing stertorously; the right side paralyzed and the left convulsed; left eye intolerant of light, the right insensible to touch and light. At the bottom of the wound was a depressed fracture, at the anterior part of the left parietal bone. The history of the case pointing to gradually increasing compression of the brain on the left side, probably from effusing blood, the wound was explored, and some overhanging bone removed with a trephine, and the depressed portion raised and withdrawn, with some splinters that had been driven under the sound portion of the parietal bone. There was a free flow, uncontrolled by pressure on the carotid, of dark-coloured blood, but no wound of the dura mater was detected. A firm compress and bandage were then applied.

Next morning the man was quite conscious and in so far improved. The convulsions on the left side had ceased. The right side was still paralyzed as to motion, but when his hand or foot was irritated he used the left hand or foot to protect himself. He perfectly understood all that was said to him, and readily at-

tempted to do all that he was directed. He did not protrude his tongue when asked, but it did not seem as if that were from paralysis of that organ, as he opened his mouth and showed the tip of the tongue, which was in the median line. He continued in this way until the fifth day, his breathing gradually becoming more difficult, and he died. From the time he was first seen by Mr. McCarthy until his death he never uttered a word, nor could he write, although he made several attempts to do so.

At the post-mortem examination the fracture was found to have traversed the course of the middle meningeal artery, which had not, however, sustained any injury. There was a laceration of the dura mater, some distance from the margin of the opening in the bone, which had doubtless been caused by one of the splinters removed at the operation having been driven through it at the time of the accident. There was no blood between the dura mater and bone, or in the arachnoid sac. There was a very little ecchymosis in the pia mater at the bifurcation of the Sylvian fissure, and beneath that a very small clot in the brain-substance. On tracing this there was found a large clot imbedded in the frontal lobe at its posterior part, coming to the surface by only a very small extent. It occupied the portion of the lobe corresponding to the interior and posterior part of the external frontal convolutions, and very closely bordered on the central lobe. When the clot was removed the brain-substance presented the usual appearance when a clot has been found after an apoplectic seizure. The right hemisphere was ecchymosed very superficially. The vessels of the brain were much diseased. The basilar artery was varicose and opaque, and the inner coat was readily peeled off, showing the atheromatous degeneration beneath. The middle cerebral artery and its branches were in a similar condition. The other viscera were normal.—*Lancet*, Nov. 16, 1872.

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*Cases of Anæmia of Optic Nerve treated with the Hypodermic Injection of Strychnia.* —C. J. W. Pinching, late dresser in the eye wards, reports (*Brit. Med. Journ.*, Oct. 26, 1872) the following cases treated in Guy's Hospital. The solution used consisted of eight grains of the nitrate of strychnia in an ounce of water. The treatment was commenced by injecting ten minims into one of the temples three times a week, and the amount was increased or diminished as seemed necessary. A very large amount of the injection (twenty-five minims) was used in some cases without any bad symptoms. In the cases that improved under treatment, one eye only seemed to recover; but, although the patients were on the whole able to see much better, no change was observable by the ophthalmoscope.

The test-types referred to in the following report of cases are those of Dr. Snellen of Utrecht.

Case I.—Sarah M., aged 36, married, no family; catamenia regular. Three years ago, her right leg was paralyzed. She had regained use of it since, and had walked for the last twelve months. At the time of the seizure, her sight became so dim that she could not read; her left eye became worse, and for the last eighteen months she had scarcely been able to see the window with it. She could see with her right eye to go about. On admission, her right eye was sensitive to reflected light, and with it she could see coloured letters on a black ground (type XX), one or two of which she could distinguish. With her left eye she could not see reflected light, and called the A of type C C something black on a white ground. The ophthalmoscope showed in both eyes an optic disk, white throughout and the veins of the retina somewhat dilated, but much below par as regarded number.

In this case, I injected ten minims three times a week for a fortnight, with slight improvement, the patient being able at the end of the time to read three letters of type VI with her right eye. I then increased the amount to fifteen minims, and continued for another fortnight with steady improvement, the patient being able to read all type IV, and some few letters of type III. I increased the amount to twenty minims; after the first injection she

was giddy, and could not walk for a short time, but after this there was no bad symptom. I continued for a week, when she had to go into the country for a month. She was now able to read type III well with her right eye; her left eye had made no improvement. The ophthalmoscope showed no change.

She returned, after a month's absence, in the same condition as when she left. I now continued an injection of ten minims for a month, at the end of which time she could read most of type II with her right eye. She went away again for three weeks, and returned, her right eye being as well as when she left the hospital, her left having made no improvement since the commencement of the treatment. The ophthalmoscopic appearances remained the same as on admission.

Case II.—Susan G., aged 24, single, dressmaker, had always enjoyed good health; her catamenia were regular. Five weeks ago, she found she could not read, and, a little later, that she could not thread her needle; she gradually became worse.

On admission, she could just see light with her right eye, and could tell when a hand was passed before her face. With her left eye she had good perception of light and reflected light, and could read type XL and a few letters of type XXX. The ophthalmoscope showed that both optic disks were white throughout. In this case, I injected ten minims for a month, with steady improvement; at the end of this time she was able to read type VIII with her left eye. I continued for another month with the same amount, but she made very little progress, sometimes being able to read a few letters of type VII. At this time, she left the hospital, her right eye having made no improvement. The ophthalmoscopic appearances had not changed since admission.

Case III.—Eliza H., aged 36, single, artificial flower maker, had worked a great deal by gaslight. The catamenia were regular. She could see well with both eyes seventeen months ago. Nine months ago, she could not read with the right eye. At this time, the left eye also became diseased, and she lost the sight of it very quickly; she had not been able to see her way about for six months. There was no history of bad sight in her family. She had had pains in her head for two years. On admission, she could just distinguish the windows and fire with both eyes. The ophthalmoscope showed, in the right eye slight anæmia of the optic disk, and numerous atrophic black pigment patches throughout the choroid. In the left eye the optic disk was slightly anæmic. The blood-supply to the retina was defective; the veins were slightly varicose. In this case, I injected ten minims for a fortnight and increased the injection to fifteen minims for another fortnight, without the slightest change taking place.

Case IV.—Walter H., aged 19, had always enjoyed good health; had never smoked nor drunk. He could see to read quite well a month ago, when he thought he "caught cold in his eyes," since which his sight had been going gradually.

On admission, perception of light and of reflected light was good with both eyes. He had no discrimination of colours. With the right eye he could see to read type XXX; with the left he could see the A of type CC. The ophthalmoscope showed in both eyes an optic disk, white throughout, and slight anæmia of the retina. In this case, for three weeks I injected ten minims, with slight improvement in the right eye. I then increased the amount to fifteen minims for a fortnight, with marked improvement, the patient being able to read type X with his right eye, and one or two letters of type LXX with his left, and to distinguish the colours blue and red with both. After a month's absence he returned, still in the same condition. I injected ten minims for a fortnight, when he left the hospital, able with his right eye to read all type IV and most of type III, and to distinguish yellow and blue, calling red purple. His left eye made no further progress. The ophthalmoscopic appearances were not changed.

Case V.—David M., aged 45, single, an engineer, with no history of syphilis, had smoked largely (an ounce of shag tobacco daily), and drunk considerably of spirits.

Eighteen months ago he arrived in Russia with perfectly good sight; fifteen months ago, while still in Russia, his feet and legs began to swell, and they pitted on pressure. A week after this his sight failed quite suddenly, and the next day was so imperfect as to compel him to leave off work, which he had been unable to resume, his sight still continuing in the same state.

On admission, he complained of numbness and pain in the feet and legs; they were not swollen. There were no cerebral symptoms. He had good perception of light and reflected light with both eyes; he could read type XVIII with his right eye, and type XX with his left. The ophthalmoscope showed, in both eyes, anæmia of the inner two-thirds of the optic disc, and anæmia of the retina; otherwise they were both healthy. I here injected ten minims for five weeks, with gradual improvement, the patient being able to read type V with his right eye at the end of this time. I then increased the amount to fifteen minims, and continued it for three weeks, but without improvement. The left eye remained the same as on admission. The ophthalmoscope showed no changes.

I also took under my care two of Mr. Pye-Smith's cases (Nos. V and VI, reported in the *British Medical Journal* of May 18th, 1872) which had been unsuccessful under galvanism, but, I am sorry to say, without good result.

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# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

### TO OUR SUBSCRIBERS.

Observing the words "No. 361" on the title-page of this number, we are reminded of the fact that the "Medical News and Library" has completed its thirtieth year, and has entered upon its thirty-first. During this time it has been the witness of many vicissitudes in medical journalism. Few of the contemporaries who gave their kindly greeting to its first number are still in existence; indeed, if our memory serves us aright, only the "American Journal of the Medical Sciences," and the "Boston Medical and Surgical Journal" survive. It has seen many promising enterprises started, full of hope, and with the brightest assurances of success, only to perish after an unavailing struggle with the obstacles which are sometimes not to be overcome by the highest deserts. It has welcomed its present contemporaries one by one into the field of common labor, and has watched their growth with the interest which should inspire fellow laborers in a cause so sacred as that of medical progress. It has sedulously cultivated the most friendly relations with all, and it has no memories of strife to embitter the retrospect.

We feel that in our own modest and unpretending way we have not failed to render the service which we anticipated when we commenced the enterprise. As we look upon the solid row of thirty completed volumes we see them filled with the record of scientific progress during an era of development that has no parallel in previous medical history. In merely that portion of our pages which has been devoted to our "Library Department" we have been instrumental in spreading broadcast before the profession many of the works which have done the most to influence the professional mind and stamp their impress upon the age. Beginning, as we did, with the classical lectures of Dr. Watson "On the Principles and Practice of Physic," which we were the first to lay before the American profession, we have furnished to our readers Sir Benjamin Brodie's "Clinical Lectures on Surgery," Todd and Bowman's "Physiological Anatomy and Physiology of Man," West's "Lectures on the Diseases of Children," Simon's "General Pathology," Malgaigne's "Operative Surgery," Bennett's treatise on "Tuberculosis," West "On Diseases of the Os Uteri," Brown "On the Surgical Diseases of Women," West's "Lectures on the Diseases of Women," Habershon "On the Alimentary Canal," Sir James Simpson's "Clinical Lectures on the Diseases of Women," Smith "On Consumption; its early and remediable Stages," Salter "On Asthma, its Pathology, Consequences, and Treatment,"

Handfield Jones's "Clinical Observations on Functional Nervous Disorders," Erichsen "On Railway and other Injuries of the Nervous System," Hudson's "Lectures on the Study of Fevers," Eustace Smith "On the Wasting Diseases of Children," Radcliffe and others "On Diseases of the Spinal Column and of the Nerves," and Dunglison's translation of Guersant "On the Surgical Diseases of Infants and Children," making in all twenty octavo volumes, some of them of large size.

We think that our subscribers have had no reason to complain, and the fact that we never addressed so wide a circle of readers as in the year 1872, and that some old friends who subscribed for the "News" at its commencement are still upon our books, would seem to show that we have succeeded in our task.

At the mature age of thirty completed years the "News" feels that it is still in its early vigour. Never have its arrangements been more complete for supplying an abundance of professional reading to its subscribers, and never have the prospects been more promising for an enlarged sphere of usefulness. When thirty years more of its career have been numbered, we feel assured that our successors, in the year of grace, 1903, will be earnestly engaged in ministering to the intellectual needs of a still larger body of readers of a new generation.

—

*Injury to Lower End of Femur; Excision of five and a half inches of that Bone; Recovery.* By Aug. Campbell, M.D., of Dunleith, Ill.

Henry A., German, aged 18, while working with a threshing machine, was caught in the tumbling rod. He had on a large pair of strong duck overalls, one of the legs of which was caught and drawn above the knee, and then the force exerted at right angles to the femur. This bone separated at the epiphysis, and five or six inches of it, entirely denuded of its periosteum, was driven through the external part of the leg into the dirt. I decided on a conservative course—to remove the end of the bone and wait. I accordingly removed five and a half inches of the femur, dressed the wound with water dressing, made extension and counter-extension with a straight splint. There was a profuse discharge and some small spicula of bone worked out. I afterwards dressed it with a starch bandage. One year after the injury, he was walking without crutch or cane. The following year and since he has done the usual work upon a farm. The leg is about one inch and three-fourths shorter than the other. The foot moves upon the radius of a circle about twenty inches. The patient, although liable to corns and cold toes, says he prefers the old leg to one of Palmer's best. [Accompanying the above account was an excellent photograph, taken a year after the accident, exhibiting the appearance of the patient at that time.]

—

*On Some of the Uses of Carbolic Acid.* By J. F. Macdonald, M.D., of Hopewell, Nova Scotia.

In the *Medical News* for December, 1872, I noticed an article on the Local Treatment, by Carbolic Acid, of Diphtheria, by Dr. H. Reynolds, of Maine. I wish to add my testimony to the use of carbolic acid in the treatment of that disease.

About four years ago I began to use carbolic acid in the treatment of inflammatory sore throat and tonsillitis, in which I found it very useful. I use a gargle of a weak solution of carbolic acid, with chlorate of potassa. In severe cases I apply, by means of a camel-hair brush or wisp of cotton, a solution of the acid and water equal parts.

In October, 1870, I first used carbolic acid in the treatment of diphtheria, and have, thus far, found it eminently successful. I apply, by means of a camel-hair pencil or cotton wisp, to the part affected, carbolic acid 15 parts, water 5 parts, or equal parts of each. I also use a gargle of a solution of the acid and chlorate of potassa.

In toothache it acts like a charm; in most cases relieving pain almost instantaneously. I apply the pure acid on lint to the carious tooth, repeating, if necessary, till pain is relieved. The acid kept in so-

lution by adding one-twentieth of its bulk of water is preferable. It will not injure the sound teeth.

I have treated some skin diseases successfully by means of carbolic acid. In scabies I never knew it fail. I have found it safe, and not unpleasant. A professional friend told me a year ago that "Carbolic acid was his specific in treatment of itch."

In herpes, eczema, tinea, psoriasis, and acne, I have found it very useful. In eczema infantilis it is especially useful. I have never seen it fail in producing a speedy cure.

The solutions I generally use are, acid. carbol. ʒj, or ʒij, aq. ad Oj, or, what is better, the acid dissolved in glycerine. In tinea tonsurans I apply, by means of a camel-hair pencil, acid. carbol. 15 parts, water 5 parts; it will rarely need a second application.

Internally I have used carbolic acid, but cannot say that I have seen any benefit from its use. In nausea and vomiting of pregnancy, in my hands, it has been a failure.

—

*Death by Chloroform, and alleged Death by Ether.*—Dr. Henry J. Bigelow, of Boston, contributes to the *Bost. Med. and Surg. Journ.*, Oct. 24, 1872, an able review of the cases of "death from ether," reported in the *Medical Record* of Oct. 1st, 1872 (see *Medical News*, Nov. 1872).

Dr. Bigelow ascribes the death of this patient to having been gradually narcotized with ether until life was extinguished.

"If the narcotism[1] of ether," he says, "is ever fatal to an aged or exhausted subject, in the way described, it should be remembered that chloroform would be more fatal to the same patient under the same circumstances.

"*Death from narcotism*, although it may be heralded as 'death from ether,' is not death from any property peculiar to ether. It is death from a depressing influence, common to ether, chloroform, alcohol and opium, and is most likely to occur with the strongest of these agents. Moreover, *precaution will prevent it.*

"But '*death from chloroform*,' which has given to chloroform its doubtful reputation, is a different thing, which *no human foresight can avert.* It is death from a small and usual dose of this powerful agent; death to a healthy person, sometimes as sudden as by a stroke of lightning, without warning of any sort—*by shock.* We hold that *ether has never produced such a result*, but always gives fair and adequate notice of the approach of danger.

"If these views are correct, it follows that a certain small proportion of 'deaths from chloroform,' so called, should be subtracted from its bill of mortality, and credited to a 'narcotism' common to ether and chloroform. But a similar analysis will wholly expunge the two or three fatal cases, for which ether has been by some persons held to answer. Chloroform will still be responsible for its monthly record of death by '*shock*,' small in its percentage it may be, but inevitable, while ether will then have a clean bill of health."

Dr. Bigelow says, if called upon to indicate in the absence of complete evidence, the probable cause of this death, he should perhaps rearrange the statement somewhat as follows:—

"A man of nearly 70 years, reduced by a fracture near the trochanter, of eighteen days' standing, and by pneumonia, was subjected to a somewhat protracted inhalation before coming under the influence of ether. At the end of ten or twelve minutes, his breathing became so feeble and irregular that etherization was suspended and artificial respiration was resorted to. In the course of four or five minutes more, there being some muscular action, the respiration being also stronger, and the pulse better, the ether was again administered, but the same bad symptoms soon supervened. On examination, the pupils were now found to be dilated. The heart was still beating (although there was probably no pulse at the wrist), but attempts at resuscitation were this time ineffectual.

[1] The term "narcotism" expresses well enough for present purposes, the gradual effect upon the system of anæsthesia in general, while "shock" may stand for the sudden or toxic effect of chloroform.

"Such an account would better accord with previous experience. The vitality of a patient enfeebled by age and disease, proves to be easily depressed, and after giving to the operator good and sufficient warning of his enfeebled condition, he succumbs; an occurrence which may serve as a fresh and salutary lesson to the surgeon to exercise care during anæsthesia by ether, and still more by chloroform, of a system thus depressed; but an accident we believe to be impossible to ether, with the pulse held and the respiration attended to.

"On the other hand, we repeat, no precaution yet devised by human ingenuity will prevent the insidious shock of chloroform, in even a small dose, from occasionally and abruptly killing a healthy subject. This is the peculiar and usual *death from chloroform*, and of its approach, neither pulse nor breathing gives indication."

—

*Library of the College of Physicians of Philadelphia.*—The increase in this library during the past year has been very large, amounting to 862 volumes; this includes quite a number of valuable works from the library of the late Prof. Jackson, liberally presented to the college by his widow.

The whole number of volumes at present in the Library is 16,349; besides 1251 duplicates, which latter will be sold and the amount realized therefrom devoted to the purchase of other works. The above enumeration does not represent the actual number of works in the library, as frequently two or more of the small books are bound together, and in many instances a number of pamphlets are bound together in a single volume.

We may further state that since the above account was drawn up, the college has received from the widow of the late Dr. Mifflin Wistar a number of rare and valuable books, mostly folios, including the great works of Mascagni on the absorbents, of Scarpa on hernia and on the nerves, of Walter, Gall, and Spurzheim, Vicq D'Azyr, Reil, Lapeyronie, Fischer, Monro, etc., all of which formed part of the library of the late Professor Caspar Wistar, of the University of Pennsylvania.

—

*Nassau, N. P.*—This place, from its mild climate and its excellent hotel accommodations, is coming into favour as a resort for invalids during the winter season. It may be interesting to invalids from the United States to know that Dr. S. Conant Foster, an eminent physician of New York, has recently taken up his residence and will engage in the practice of medicine at Nassau.

—

*The Physician's Visiting List.*—Messrs. Lindsay and Blakiston have issued this most useful volume for 1873.

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Obituary Record.—Died in Philadelphia, Dec. 9, 1872, René La Roche, M.D., at the mature age of 78. Dr. L. was one of the oldest, most respected, and learned members of the profession in this city. His contributions to our literature were numerous and valuable. Among the most important of these we may refer to his exhaustive work on yellow fever, which is a monument of careful, patient, and elaborate research; and a valuable monograph on malarial pneumonia. He also contributed numerous reviews and original articles to various medical journals. He was, also, a gentleman of general literary culture and of great musical taste, and at one time possessed the best collection in this country of works relating to that art. He is reported to have left a manuscript work on the physiological effects of music, which doubtless, like his other literary efforts, will be characterized by extensive research and a full knowledge of the subject.

## FOREIGN INTELLIGENCE.

*Nocturnal Incontinence of Urine treated by Hydrate of Chloral.*—Dr. Girolamo Leonardi has recorded, in the *Ippocratico* of Naples, the results of the use of chloral in three cases of incontinence of urine. The administration of the drug very rapidly effected complete and permanent cure. Together with the administration

of chloral, Dr. Leonardi recommended very little drink to be taken in the evening. In the first case, a scrofulous woman, aged twenty-four, who had been constantly suffering from the complaint since the age of eighteen, chloral administered in doses of fifteen grains every night during five nights, and of fifteen grains every second night during ten nights, was remarkably successful. The incontinence was immediately stopped. A course of chloral was continued from time to time. The second case was that of a child, aged seven, who took only one-third of a grain of chloral for five nights. The third case was quite as successfully treated in the same way.—*Lancet*, October 26, 1872.

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*On Myocarditis and Endocarditis in Cases of Diphtheria, Croup, and Membranous Angina.*—In a lecture recently delivered at the Hôpital des Enfants, Dr. Bouchut laid stress on the frequency of disease of the heart in cases of diphtheria and other septic diseases. The endocarditis, he said, was valvular and parietal, of a proliferating character, and was accompanied by fibrinous deposits on the diseased walls, and of large ventricular clots. The fibrinous deposits adhering to the diseased valves may become loose, and be carried away by the blood into the aorta or pulmonary artery, and there give rise to embolisms. These embolisms form infarcti of the lungs, followed by metastatic abscesses and cutaneous infarcti, with or without consecutive abscesses and infarcti of the brain, which may produce cerebral softening.—*Lancet*, October 26, 1872.

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*Calcareous Infiltration of the Heart.*—Dr. Coats, Pathologist to the Royal Infirmary, and Lecturer on Pathology in the University of Glasgow, has recently called attention in the *Glasgow Medical Journal* to two cases of a very rare affection—calcareous infiltration of the muscular fibre of the heart. Indeed, in regard to one of the cases he records, Dr. Coats states that he does not find, either in English or foreign literature, any description of a similar lesion. The lime salts had been deposited in the muscular fibre in the form of minute round granules, the appearance resembling, both to the naked eye and microscopically, that of fatty degeneration. The salt was probably composed entirely of phosphate of lime. The case was one of chronic bronchitis and emphysema, with a possible syphilitic taint. In the other case, the condition of the muscular fibres closely resembled that described by H. Meyer and Förster, and alluded to by Rokitansky. The muscular fibres of the heart, much resembling asbestos in appearance, were converted into rigid cylinders, having a considerably crystalline texture. The lime salt was deposited more homogeneously, and consisted in great part of carbonate of lime, which effervesced on the addition of hydrochloric acid. The morbid specimen was removed from a patient who died of pyæmia.—*Lancet*, October 19, 1872.

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*Alleged Substitute for Quinia.*—M. Gustave Doray, a *pharmacien* residing at St. Lô, has addressed to the Academy of Medicine in Paris a note on the febrifuge and anti-periodic properties of the *Laurus nobilis*. He states that Drs. Letouzé, Alibert, and Scelles, of Mondésert, have given it in thirty-four cases, of which twenty-eight were successful; some being cases of pernicious intermittent and others of obstinate ague. The medicine is given in the form of a powder of the dried leaves, one *gramme* of which is administered two hours before the expected paroxysm. The Academy has appointed a Commission, consisting of MM. Mialhe, Gobley, and Bussy, to report on the value of the remedy.—*Ibid.*

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*Therapeutical Administration of Metals in Cod-liver Oil.*—Herr Godin recommends, in place of the ordinary solutions of the metallic salts, their solution in cod-liver oil by means of benzoic acid. Cod-liver oil can thus be made to take up benzoate of iron and benzoate of mercury. Benzoate of iron is a beautiful orange-coloured salt of stable character, which increases the therapeutic activity of cod-liver oil. The iron salt conceals the unpleasant

taste of the oil, and at the same time renders it more digestible.—*Practitioner*, Nov. 1872, from *Therapeutisches Beitrage zur Allgem. Med. Zeitung*, No. 31.

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*The Superiority of Ether as an Anæsthetic Agent.*—On Friday, the 29th ult., this question was freely brought before the Surgical Society of Ireland by Mr. Morgan. He introduced the question to the members with a view of eliciting full discussion of the subject as to the rival qualities of the two anæsthetics which are admittedly most suitable for surgical practice—Ether and Chloroform. He questioned whether chloroform either hitherto deserved or could longer retain the confidence of the Profession, now that deaths are more constantly reported from its use, and that they have reached, notwithstanding all precautions to the contrary, an alarming number. It is stated that in these countries the proportion is one weekly; and, if we allow that these only represent the cases of immediate death from the influence of the inhalation, we must admit it is no mean estimate.

The meeting was the largest known for some years, and the subject was found to be of such moment that its discussion was postponed to the next evening meeting.—*Medical Press and Circular*, Dec. 4, 1872.

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*Chloroform in Obstetric Practice.*—Dr. Arthur W. Edis, Physician to the British Lying-in Hospital, states (*Brit. Med. Journ.*, Nov. 16, 1872), "When called in consultation in difficult cases of labour, I have more than once been compelled to desist from my efforts at assistance, as in the application of forceps or turning, and direct all my attention to the prevention of what threatened to be a fatal issue from chloroform—the natural desire of the practitioner to watch the details of the operation possibly contributing to this result, as well as the exhaustion induced by the prolonged suffering to which the patients had been subjected before assistance had been sought. Apart from the danger of incautious administration of chloroform, I fear we must admit that the tendeney to *post-partum* hemorrhage is greater than when no anæsthetic is employed, more especially in those cases where alcohol has been liberally indulged in as a habit, and where, therefore, a larger amount of chloroform than usual is needed to produce the requisite amount of anæsthesia.

"I have long been in the habit of employing equal parts of chloroform and ether in all cases of labour, and consider that the risks, both primary and secondary, are less than when the former is given by itself; there are less nausea and depression, and the tendency to hemorrhage is diminished."

—

*Vaccination in Smallpox.*—The *Allgemeine Wien. Med. Zeitung* states that the following conclusions, though not based on statistical returns, have been arrived at by those physicians who have watched the progress of the present epidemic of smallpox in Vienna. 1. The mortality from smallpox is nearly ten times as great in the unvaccinated as in the vaccinated. 2. The average intensity of the disease is also much greater in the former than in the latter. 3. Hemorrhagic smallpox is much more common in the unvaccinated. 4. In the children's hospital, where the mortality from variola is very great, and hemorrhagic cases very frequent, the unvaccinated suffer most. Similar conclusions have already been arrived at in this country; and the experience of the Vienna physicians is an additional testimony to the value of vaccination. We trust that sufficiently careful records have been made during the present epidemic to afford a basis for a statistical statement, when the scourge shall have passed away, of the influence of vaccination on smallpox.—*Ibid.*

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*Removal of one-half the Tongue.*—Drs. Puccioni and Gozzini, of Florence, have just performed removal of one-half of the tongue, in a case of epithelioma, by means of the galvano-caustic wire. The whole operation did not last seven minutes, produced scarcely any suffering, was without the slightest loss of blood, and attended by no febrile reaction. The authors employed the double-wire process which they have invented.—*Lancet*, Nov. 2, 1872.

*A Certain Sign of Death.*—Dr. Hugo Magnus, assistant physician in the hospital at Breslau, states (*Virchow's Archiv*, Aug. 1872) that indications of death drawn from the circulation of the blood and from the respiratory movements are of the utmost value, since if these have entirely stopped it is impossible that life can be maintained. Dr. Magnus recommends that a ligature should be tied tightly round some member of the body—a finger is well adapted for the purpose—when, if the slightest trace of life remain, increased redness will be observed in the part beyond the ligature. The tint gradually becomes darker and deeper till ultimately it assumes a bluish-red, and this tint is uniform from the tip to the point where the ligature is applied, except that in the immediate proximity of the ligature is a white line. This test appears to be a good one, and is founded on physiological facts.—*The Practitioner*, Nov. 1872.

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*Post-mortem Delivery.*—Two cases of this are recorded in the *Indian Med. Gaz.* Aug. 1, 1872, one by Dr. Claghorn, the other by Dr. Baillie. The subject of the first case was brought for examination and remained in the dead house all night. In the morning Dr. C., found a fœtus about the fifth month of utero-gestation inclosed in its membranes lying between the thighs of the corpse. Dr. C. says he has met with another case of this kind.

The subject of Dr. B.'s case had died from snake-bite, and was placed in the dead-house. The next morning a fœtus was found to have been expelled during the night and lay between the mother's legs. The body was very much decomposed.

—

*Medical Education.*—The *British Medical Journal* (Oct. 12, 1872), in criticizing the Introductory Address delivered this year by Mr. Christopher Heath, at University College, makes the following just remarks, which we commend to the attention of the profession in this country:—

"Notwithstanding the tendency of surgeons of a certain quality of mind to depreciate culture and to favour the traditions of barber-surgery, it was hardly to be expected that a surgeon should be found to lay before students at University College the sort of views which are expressed in the oration delivered by Mr. Christopher Heath, of which we last week published the abstract. He desired them to understand that the work required for the degrees of the London University implied, except for the purposes of merely honorary distinction, so much time thrown away. If they had abundance of spare time and cash, they might aim at the decorations, since other people seem to think a good deal of them; but for this purpose thay must waste their time in learning 'science.' Such dicta are very likely to be acceptable to students; for to follow them saves a great deal of trouble, and to adopt them affords a cheap sneer at the distinctions which they will probably fail to gain, and at the knowledge and power which they will neither acquire nor appreciate." . . . .

"The Arabian rage against books and learning has lost some of its importance; but it seems still to be as innate in the uncultivated mind as when it lit the flames of Alexandria, and sought to deliver over the world to practical men, whose common sense dispensed with learning, and achieved two centuries of intellectual dulness. This is not the moment to attack the foundations of higher education, or to endeavour to arrest the efforts which we are making to train a race of well-grounded investigators, who shall not be content to leave original investigation to Germany or to France, or to live in abject veneration of the few who know how to handle the facts, while they themselves have but learnt by rote the words or formulæ of medical science. We would have a race of real, earnest, cultivated workers; and for this end it is advisable that Mr. Heath's advice should be noted as precisely indicating the point of view which is most to be shunned, and the course which is to be most strictly avoided."

—

*Dengue.*—It is stated that this disease, which has for some time prevailed so extensively in India, is now prevalent in China.

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## LECTURES.

### *The Relative Frequency of Disease between the Right and Left Sides of the Heart—Degeneration of the Heart; its Causes and Means of Avoidance.*

By CORNELIUS BLACK, M.D. Lond., M.R.C.P., Corresponding Fellow of the Imperial Soc. of Phys. of Vienna, etc. etc.

If the question were asked, "Which side of the heart is the more frequently affected by disease?" the answer in perhaps nine cases out of ten would be that the left side of the heart is the one which more frequently suffers. This answer would not, however, embrace the whole truth. It would be true of the aggregate of cases of cardiac disease without reference to age; but it would be untrue if the occurrence of cardiac disease were referred to the later periods of life. If a man lives to the age of forty years without having suffered from cardiac disease, and if after that period the heart becomes affected, the mischief will, as a rule, be found to exist on the *right* side. If, on the contrary, cardiac disease should occur before that age, the disease will almost invariably be found to exist on the *left* side. Hence it follows that the right side of the heart is the seat of cardiac disease occurring after middle age—the left side of the heart the seat of cardiac disease occurring before middle age.

As in time, so it is with respect to the nature of the diseases which affect the right and left sides of the heart respectively. Those of the right side are the result of tissue-degeneration, or of mere mechanical influences; those of the left side are almost invariably the product of inflammation. The former are diseases

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which tend to widen the valvular apertures and to dilate the right side of the heart; the latter are diseases which tend to contract the valvular apertures and to increase the size and bulk of the left side of the heart.

Disease of the right side of the heart is essentially passive and secondary in its character; disease of the left side of the heart is essentially active and primary in its character. I speak now of disease when it occurs, not when it has existed for some time. Active inflammation of the left chambers of the heart arises; it progresses to a certain extent; treatment subdues it; the patient recovers; but a certain amount of damage is left behind. Years pass on; the patient during this time appears none the worse for his previous illness; but at length pulmonary symptoms suddenly manifest themselves, and then it is that the physician discovers that the left side of the heart is permanently damaged, and that the present condition of the lungs is traceable to this cause.

In this instance the mischief in the heart inducing this condition of the lungs is not, strictly speaking, active. The first step of the cardiac disease was active; but the second step was chronic. Bit by bit—increment by increment—after the patient's apparent recovery from the primary attack, is the valvular lesion left by such attack added to, not perhaps constantly, but intermittingly, until at length the aggregate increments of addition so hamper, oppress, obstruct, and distort the mitral or the mitral and aortic valves, that secondary consequences begin to follow.

In such a case the cardiac disease producing the first degree of valvular lesion was *active* or *acute;* whilst that which really induced the secondary consequences —congestion of the lungs, hæmoptysis, hypertrophy of the lower lobes, or hypertrophy of the left ventricle—was essentially chronic.

Why are the affections of the two sides of the heart essentially different in their nature? Why do those of the left side of the heart point to an inflammatory origin; those of the right side of the heart, with but few exceptions, to a non-inflammatory origin? There must be some cause for this difference. What is it? The reason is found in the difference which exists between the constitution of the blood which reaches the left side of the heart from the lungs and that which reaches the right side of the heart from the general system. The blood reaching the left side of the heart from the lungs has been replenished with all the elements necessary for the growth of the tissues; it has been purified, renovated, and vivified by its oxygenation in the lungs, and it is thus rendered in the highest degree stimulating to the left heart. The blood reaching the right side of the heart from the general system has been deprived, by the requirements of growth, of the chief portion of its nutrient materials; it has been fouled by the débris of tissue-waste; it has been further poisoned by its impregnation with carbonic-acid gas; it is therefore a depressant, rather than a healthy excitant, to the right heart. True, it brings with it to the chambers of the right heart the products of the digestion of food; but what are they, either as nutrients or excitants, when they reach that point? They are no more than inert, unusable, passive elements. Not until they have passed to the lungs, and have there received the vivifying influence of oxygen, can they enter into the real composition of the blood, and thus become active, exciting, disposable constituents of it.

"Like begets like" in very many instances. This axiom is true in relation to diseases of the heart. The rich stimulating blood of the left ventricle urges, feeds, and actively supports any disease which may arise at that point; whilst the poor, impoverished, fouled, tainted, and attenuated blood which flows through the cavities of the right heart favours disease of a correspondingly low and degenerate character.

So long as the body is rapidly built up and as rapidly pulled down, disease of the left heart maintains an active character; but when the balance between nutrition and waste is destroyed—when nutrition becomes less active, whilst waste remains the same, or is more active than before—

disease of the left heart loses more and more of its active character, and approximates more and more in its nature to disease of the right heart. In many this change begins at the age of forty; in others, not until five or ten years after that period. Thenceforward the tendency to inflammatory disease of the left heart declines—the tendency to degeneration increases. With the gradual declination of the one tendency and the gradual increase of the other, a period is at length reached when active inflammatory disease ceases, as a rule, to affect the left heart. At this juncture the left and right sides of the heart, hitherto dissimilar in their tendencies, are in this respect almost as one. The active tendency of early life has given place to the passive tendency of advancing years —inflammation to degeneration.

Acute rheumatism—a fruitful cause of cardiac disease in the earlier periods of life—is seldom seen beyond the age of fifty. I have, however, attended a case of acute articular rheumatism at the age of seventy-five; but such an instance was an exception to the rule. After fifty, acute rheumatism gives place to a form of rheumatism which slowly produces rigidity of the coats of the bloodvessels, hardens and contracts the tendons, thickens and renders stiff and rigid the ligaments of the joints, hardens and lessens the articular cartilages.

Thus, then, according to a law of nature the *ultima linea* of life ends in—degeneration.

Apart from the influence of this law, can any accidental, casual, or avoidable circumstance favour this immutable tendency to degeneration, speaking more particularly in reference to the heart? Yes; many circumstances are daily, hourly, momentarily doing this. Thousands annually perish from heart disease, whose lives might and would have been prolonged had but proper attention been given to the simple laws of nature. These laws demand attention to the three great vital functions—the action of the brain and nervous system, respiration, and circulation.

None of these functions must be overworked, as none of them must fall short of their proper duty. Healthy, regular, daily action is their law of life. If the brain and nervous system are overworked, vitality is lowered, the resisting power of the body is diminished, disease is easily produced. If the brain and nervous system are underworked, the generation of nervous power is low and deficient, the vitality of the tissues becomes low in proportion, and disease is easily excited. Overwork exhausts, ruins, kills the body, just as the continued generation of the galvanic current exhausts the acid and wears out the zinc plate. The weakest point of the body has to bear the result of this violation of nature's laws. If the heart is that point, disease falls upon it, and death before the legitimate term of man's existence is the consequence.

To keep the body in perfect health it must be duly oxygenated. There must be free and ample interchange between the blood in the lungs and the air entering the pulmonary cells. The life-stream must be purified by its elimination of carbonic acid; it must be vivified by the absorption of oxygen. The fulfilment of these conditions demands a full, free, and constant admission of pure air into the lungs. This full, free, and constant admission of pure air cannot be obtained in badly-ventilated houses, crowded buildings, schools as at present constructed, theatres, manufactories, pits, underground railways, and the like.

When the body has reached that age at which natural decay or degeneration has begun, the absence of pure air hastens and increases the degenerative tendency. Where the heart is more prone than other organs to disease, the want of pure air falls with powerful effect upon the tissues of the right heart. Their nutrition is defective by reason of the impurity of the blood with which they are fed, their vital force is lowered, their muscular fibre loses its tonicity, degeneration and debility take the place of active nutrition and power. If in this condition any stress is thrown upon the heart by hurried walking, by lifting, climbing, violent declamation, passional expression, singing, laughing, or by any unusual exercise of the voice, the tricupsid valve gives way, it henceforth fails to close its aperture, and the

results of a back-flooding of blood upon the venous system of the body begin to follow. If none of these exciting causes occur, the continued breathing of impure air is followed by constantly progressing degeneration of the tissues of the valves and muscular structure of the right heart; they become soft and feeble, their atoms shrink; the segments of the tricuspid are at length unable to meet in their attempt to close their aperture; a small chink or slit is left between them; through this the blood finds its way into the auricle above at every contraction of the heart; and soon regurgitation is followed by the secondary consequences produced in the general system—congestion of the liver, stomach, spleen, kidneys, bowels—by hæmorrhoids, general dropsy, and occasionally by cerebral mischief.

I hold that the breathing of impure air is a fruitful source of disease of the right heart occurring after middle age. How many people ignorantly favour its occurrence by confining themselves to closely-shut, non-ventilated, hot, stifling rooms in which the carbonic acid has accumulated to 2 or 3 per cent. of the air they respire! How many are thus destroyed by being compelled, through the exigencies of life, to pass the greater part of their time in pits and manufactories where ventilation is defective, or in which the air respired is poisoned by noxious fumes and offensive emanations from the materials undergoing the process of manufacture! How many are falling victims to the poisonous influence upon the heart of the atmosphere of an underground railway! What do these facts suggest? How are these evil results to be prevented? The simple answer is—Let the rooms in which you live be effectually ventilated by an incoming current of air filtered from all adventitious impurities, and so divided that no draught shall be felt; and by an outgoing current which shall remove from the apartments the carbonic acid, carbonic oxide, sulphurous-acid gas, sulphuretted hydrogen, and other noxious compounds, as rapidly as they are generated. Apply the same principle to public buildings, theatres, schools, manufactories, pits, and to all places in which people are accustomed to congregate.

As to underground railways, the best plan is to avoid them. True, the time passed in their polluted atmosphere is usually very short; but it is nevertheless sufficiently long to paralyze occasionally the heart's action, and always, by its pollution of the blood and by its direct effect upon the nervous system, to favour degeneration of the structures of the heart.

It often occurs to a medical man to visit a patient for the first time, and to find him suffering from a dilated right heart, tricuspid incompetency, some degree of hepatic enlargement, and œdema of the lower extremities. There is no asthma, no emphysema of the lungs, no affection whatever of those organs to impede the onward flow of blood from the right ventricle, no history of cardiac affection in earlier life. The patient may for some short time have been sensible of a change in his breathing on walking rather quickly, or in mounting the stairs, or he may never have felt, or at least recognized, any such sensations. His attention was first arrested by observing that his feet and ankles were swollen, especially at night on going to bed. This sign it is which gives him the first alarm, and which causes him to seek the aid of the physician. An examination of his case detects a dilated right heart, with incompetency of the tricuspid valve. How has this condition of the heart been brought about? There is no history of previous cardiac disease; there has been no illness ushering in the present condition of things; there has never been, nor is there now, any affection of the lungs, and yet the right heart has suffered a lesion fatal to life! The answer is, that every such case has passed the age of forty, that the tissues of the right heart have entered upon the period of degeneration, and that this degeneration has, with very few exceptions, been hastened by the impure air, either during the pursuit of the ordinary occupations of life, or in the patient's own dwelling.

When the degeneration of the right heart has progressed to a certain extent, incompetency of the tricuspid valve follows either with or without the aid of an exciting cause. Hence it is easy to understand why dilatation of the right heart and tricuspid incompetency are often

found to exist apart from any previous history of cardiac disease.

The third great vital function which influences the degenerative tendency of the heart is that of the circulation of the blood. To preserve the health of the tissues, the blood must not only be pure and rich in the materials of growth, but it must flow with a certain speed through all the bloodvessels. If the speed with which the blood moves is on the side of either *plus* or *minus* of the standard of health, disease will shortly arise. If it is on the side of *plus*, active disease of the heart, where that organ is the one to suffer, will follow. If on the side of *minus*, tissue degeneration will ensue. Active disease will be the consequence before middle age; degeneration after that period.

These facts teach that all violent and long-continued efforts of the body should be avoided. They hurry the heart's action to an inordinate degree, they cause it to throw the blood with great force into the extreme vessels, and, as there is almost always one organ of the body weaker than the others, the vessels of this organ become distended, and, remaining distended, the organ itself becomes diseased. Running, rowing, lifting, jumping, wrestling, severe horse-exercise, cricket, football, are fruitful causes of heart disease. Those which require the breath to be suspended during their accomplishment are more fruitful causes in this respect than those which require no such suspension of the breathing. Rowing, lifting heavy weights, wrestling, and jumping do this; and of these, rowing is the most powerful for evil. At every effort made with the hands and feet, the muscles are strained to their utmost; the chest is violently fixed; no air is admitted into the lungs; blood is thrown by the goaded heart with great force into the pulmonary vessels; they become distended; they at length cannot find space for more blood; the onward current is now driven back upon the right heart; its cavities and the bloodvessels of its walls become in like manner distended; the foundation of disease is laid. Hypertrophy, hæmoptysis, inflammatory affections of the heart and lungs, are the consequences in the young; valvular incompetency, rupture of the valves or of the muscular fibres of the heart, pulmonary apoplexy, and cerebral hemorrhage, are too frequently the immediate consequences in those of more mature years.

If the flow of blood is *minus* the standard of health, the heart's walls are imperfectly nourished by reason of a deficient supply of food within a given time; the blood itself, receiving less aëration, is in consequence more impure; degeneration of the heart's walls is thus induced, if it does not already exist—hastened, if it is present.—*Lancet*, Aug. 24, 1872.

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Clinical Lecture on Excision of the Knee-joint.* By T. Holmes, F.R.C.S., Surgeon to St. George's Hospital, etc.

Although, gentlemen, the short time allowed for the course of lectures on Systematic Surgery obliges us to be very dogmatic, there are, in truth, two sides to almost every surgical question; and it seems to me that the chief value of these clinical lectures is, that they allow us to explain, separately, these debatable points at greater length, and with the aid of illustrative cases. Excision of the knee is just such a point. It is not many years since it was first performed by Sir William Fergusson, and the number of cases operated on is even now not sufficiently large to enable us to judge of the results with perfect satisfaction. It is only lately, too, that the conditions under which the operation can be favourably performed have been at all clearly defined. In the early days of excision of the knee, the operation was performed on patients advanced in phthisis, or for malignant tumour. No English surgeon would now consider this justifiable. Yet, though the operation has, even now, scarcely passed beyond the experimental stage, its employment has been advocated and condemned with a partisanship which is, I think, quite out of place in such a controversy.

The operation has, indeed, its advantages and its disadvantages. In consider-

ing these, it has been the fashion to compare it with amputation; but we must also compare it with an expectant treatment and conservation of the limb.

*Disadvantages.*—The *shock* of the operation is very severe, and it is followed by severe surgical fever. After amputation for disease in the child, there is usually but little shock or fever; the child often sleeps soundly a few hours after the operation, and mends steadily from that time. The shock and suppurative fever after excision are, however, not often fatal.

*Arrest of growth in the limb after the operation.*—This is rather common; it is due to the removal of the whole of the epiphysis and part of the shaft of the bones. In the femur, the epiphysial line comes very close to the edge of the cartilage, and consequently, the risk of removing the epiphysis is great. In some cases this can be avoided by merely slicing off the cartilage, and leaving a rounded or truncated end to the bone; but often owing to the extent of the disease, a horizontal cut is absolutely necessary. In the tibia, the space between the articular surface and the line of junction of the epiphysis is greater, and, consequently, there is a better chance of being able to save part of the latter. Of course, the younger the patient the greater would be the relative shortening from this cause.

*The risk of soft union between the bones and of bad apposition.*—The tibia has always a great tendency to fall back, so that only the anterior part of the cut surface is in apposition with the femur, and the partial union thus formed is not strong enough to support the weight of the body; or, if the cicatrix be stronger, it may yield gradually to the weight of the trunk, and the limb may bow outwards, giving it a shortened and awkward appearance. These deformities may be corrected by splints if treated at once, and, unless the shortening and bending be excessive, the limb is still better than a wooden one. A shortening of six inches, compared with the sound limb, is no great hindrance to walking; the pelvis drops on that side, and this obliquity, with a high boot, readily compensates for the shortening.

These, then, are minor disadvantages; the real obstacles to the operation are its severity, the tedious convalescence which follows, and the liability to recurrence of the disease.

It is very difficult to judge of the comparative mortality after excision of the knee; statistics especially are very fallacious. It is not sufficient to compare the total mortality after excision with the total mortality after amputation. Even the most enthusiastic surgeons limit their practice of excision to young patients and to favourable cases, while amputation is performed at all ages, and often under desperate circumstances. Excision, again, is never done for cases of acute injury; in military surgery it has been exceedingly fatal. To arrive at any satisfactory result, we must compare *similar cases* in considerable number; and this is not an easy matter. I believe myself that the mortality after excision is about double that of amputation. I should say, too, that the period of convalescence is about four times as long after excision as it is after amputation. This estimate is, if anything, rather below the mark.

*The risk of recurrence* of the disease is not great when the wound heals rapidly; but, if convalescence be prolonged, a renewal of the caries often results. And when this does happen, do not be in too great a hurry to amputate; treat it as you would caries in the continuity of a bone; there is now no joint to complicate the treatment. Scrape out the diseased bone or apply caustics; if this do not answer, you can excise again; though this, of course, increases the shortening.

The *coleur de rose* doctrines which have been advanced by some surgeons have certainly produced very mischievous results. Excision is not an operation which can be employed indiscriminately; it must be reserved for cases of favourable age, and in which the disease is not too acute or too extensive. When it is thus reserved for suitable cases, the result is infinitely superior to that of amputation. The advantages, indeed, are more marked the earlier the age of the patient.

Amongst the lower orders, amputation of a leg almost ruins a child's prospects

for life; few will have anything to say to him, and the greater part of his life is passed at the cripples' home in the workhouse. But after excision he is fit for a sedentary or even for a moderately active life. I have known patients who could easily walk ten and fifteen miles a day after excision; and a German surgeon has recorded the case of a man who was able to follow successfully the ardous profession of a chamois-hunter after this operation. After middle life, the advantages are doubtful. The result of the operation is not generally so good, and an adult can seldom afford the long period necessary for convalescence. The complete use of the limb, after excision of the knee, is not fully acquired for some years.

On the other hand, the number of cases which are available for excision, even in the child, are limited by the fact that many of them are curable without any operation, if you can only give them time. In private practice, amongst well-to-do people, where the parents will readily nurse a child for three or four years, you may cure cases of abscess in the knee-joint, or even of chronic disease of the bones, by means of simple expectant treatment, and may even get a tolerably useful joint. In hospital practice this plan of treatment is impracticable, and then it is that, by excision, you can hasten and facilitate the process of cure without materially altering the nature of the result.

On the whole, then, whilst I fully recognize the advantages of excision, I am strongly in favour of the close restriction of the operation to a limited class of cases.

So far, we have been dealing with the operation in the abstract. We have now to consider, more particularly, the principles which should guide us in the selection of cases, the best mode of performing the operation, and the necessary after-treatment.

*Age.*—The patient must be under forty or forty-five. The elbow or shoulder may be successfully excised at a much greater age; but, after middle life, excisions in the lower extremity are exceedingly fatal. In the case of very young children, free incisions into the joint and expectant treatment are so successful, that formal excision is seldom necessary; the risk of getting an excessively shortened limb is also very great. This is not absolute contra-indication, since excision may be, and has been, practised successfully in early infancy; but the most favourable age for the excision of the knee may be said to be between five or six and twenty. The operation may, however, be performed, with fair hope of success, when the other circumstances are favourable, as late as thirty or even beyond.

*Constitutional state.*—There must be no visceral disease. The lungs must be examined for signs of phthisis, and the urine for evidence of the albuminoid kidney, which often accompanies chronic disease of the bones; nor should examination of the liver be neglected. There must be no acute surgical fever, and no marked depression of the general health; no great wasting or confirmed hectic.

*Local state.—a.* The bones must not be too extensively softened. Unless you can remove all the softened bone, you will be almost sure to get soft union or no union at all. In excision of the elbow, and even of the hip, this objection does not hold good—you do not want to get firm osseous union, as you do in the knee. In many cases, it is quite impossible to diagnose the actual state of the bones before the operation; you must, therefore, always be prepared to change your excision into an amputation, and must always previously obtain the consent of the patient or of his friends to this course if necessary.

One of the most favourable classes of cases for excision are those of so-called "strumous" disease of the synovial membrane, though the patient often shows no sign whatever of the strumous diathesis. It is characterized by pulpy degeneration and thickening of the synovial membrane, and by the frequent presence of small abscesses in the thickness of this pulpy mass, which may, or may not, have burst into the joint; the bones are scarcely affected at all. The operation also is exceedingly simple in these cases; you need not be particular about removing all the thickened synovial membrane, and have

only to remove a thin slice of bone and cartilage from the articular surfaces.

Then there are the cases where a superficial necrosis of some part of the articular surface has taken place, and a sequestrum has formed. In some of the other joints you may just remove this sequestrum, and trust to rest, etc., but in the knee this procedure is followed by such severe shock and profuse suppuration that it is better to excise at once.

*b.* The disease must not be of too long standing, and the limb must not be too much atrophied. In children especially, if the disease have lasted for any considerable time, there is great risk that it may have extended beyond the epiphyses, and that the operation would consequently be followed by arrest of growth in the limb.

*c.* The soft parts must not be too extensively undermined.

*d.* The disease must not be in an acute stage. I have seen excision successfully performed for acute abscess in the knee-joint, but, as a rule, the operation under these circumstances should be discountenanced. This rule also does not hold good in the case of other joints, especially of the elbow, where excision may be safely recommended in the acute stage of abscess.

It will thus be seen that the most favourable cases of disease of the knee-joint are those which are selected for excision, whilst the more unfavourable are left for amputation, and that this, therefore, tends to increase the mortality after amputation. Some have argued that the tendency is to some extent neutralized by the fact that, since the introduction of chloroform, amputation has been performed in many favourable cases of old deformity, etc., which would formerly have declined the operation. This may be true, but, on the other hand, a far larger number of favourable cases are saved by the conservative surgery of the present day, which would formerly have undergone the operation; so that I do not doubt that, on the whole, amputation for disease is now practised in a class of cases less favourable for recovery than was formerly the case.

The *Operation* itself is tolerably simple. Some surgeons, as Mr. Butcher, still adhere to the H-shaped incision; this, however, is rarely required—only when a joint is ankylosed in an awkward position, or when you wish to expose the bones very freely. Others make a large anterior flap, inclosing the patella; the only advantage of this is that you can at once amputate, if necessary, without removing much of the femur; the objections are, that there is a large hollow left after the removal of the patella, and that the wound is larger, and, consequently, the shock is increased and convalescence retarded.

Langenbeck, I believe, operates, or used to operate, on a totally different plan, and with a different object in view. He makes a longitudinal incision down each side of the joint, divides the lateral and crucial ligaments, and turns the articular surfaces out through one of the wounds. He leaves the patella and its ligament entire; his object being to get a movable joint, while we look for firm ankylosis. I have no experience of Langenbeck's treatment, but, from my own experience, should always advise the removal of the patella, or, at all events, of the whole of its cartilaginous surface. When the patella is left, it often becomes the seat of the recurrence of the diseaase, and, if the bones are to be firmly united and soldered together, there is no advantage to balance this risk. You will see, by the examination of such cases several years after recovery, that the quadriceps extensor cruris becomes atrophied, and the function of the patella entirely abolished.[1]

I think, then, that the best plan is to make a single straight incision from the back of one condyle to the back of the other, cutting across the ligamentum patellæ, and completely dividing both lateral ligaments. After turning up and removing the patella, the limb is well flexed the back of the condyles cleaned, and the lower part of the femur sawn off nearly perpendicular to the axis of the bone; the head of the tibia is then cleaned and sawn across horizontally. The danger to the

[1] See an illustration in Holmes's System of Surgery, vol. v. page 708. Second edition.

popliteal is not great, unless it be bound down to the back of the bones—glued to them, as it were, by inflammatory products; nor is there any motive for sawing the femur from behind forwards, as has been recommended.

Be very careful to tie all bleeding points. I always use the carbolized catgut ligatures, and cut off both ends quite short; the knots do not interfere in the least with rapid union. I find this much more satisfactory than torsion, especially for small vessels.

Put up the limb at once, before the patient recovers from the chloroform. There are several different forms of apparatus. The limb should be perfectly straight, and the splint should be carefully adapted to it. The plaster of Paris splint is very good; the best form is that of Dr. Patrick Watson, a description of which is inserted in the *System of Surgery*. The objection is that, if the limb become inflamed and swells, you have at once to take it all down; and if, as sometimes happens, the limb shrinks, the splint allows too much motion. The same objection applies in some degree to Mr. Butcher's apparatus; this consists of a sort of trough, formed by three flat wooden splints, open in front. In this hospital we usually use a McIntyre's splint, cut away at the sides opposite the joint. Wooden side splints are applied to this, and a well moulded leather splint is fitted over the front of the thigh.

Whatever apparatus you use, do not disturb the limb oftener than you are absolutely obliged; perfect rest is the great point of the after-treatment. If you can avoid any changes for four or five weeks, so much the better; by that time there will probably be a sufficient amount of union between the bones to dispense with all special apparatus for the future.

Do not allow the patient to use the limb too soon, and watch him for some little time after he begins to move about on it, so that you may at once check and correct any tendency to bending or bowing at the seat of union.—*Brit. Med. Journ.*, Oct. 12, 1872.

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## HOSPITAL NOTES AND GLEANINGS.

*Treatment of Sick Headache.*—About a year ago there was published in the *Brit. Med. Journ.* the results of the experience of a large number of leading British physicians regarding the treatment of this distressing affection. The substance of the report amounted pretty much to this: that the relief afforded by the medical man was, as a rule, so trifling that the patient took the matter into his own hands, and found by experience the best way to obviate or alleviate the attack, or made up his mind that the affection was incurable. Bromide of potassium was, however, noticed as a drug occasionally capable of affording relief. Dr. Williams, of the Sussex Lunatic Asylum, also recorded the experience, at that institution, of Indian hemp as a remedy, and stated the opinion of his colleague Dr. Greene and himself, that this drug was worthy of extended trial. Since the appearance of our report, guarana or paullinia powder, a remedy for sick headache which has been employed in France and elsewhere for some years, was brought prominently before the notice of the profession in this country by Dr. Wilks. . . . "The results obtained are very various, and show that our knowledge of its *modus operandi* is most incomplete. An extended trial of guarana, and a careful observation of the class of cases in which it is of value, will probably ere long lead to a more definite knowledge of its therapeutical value. We are glad to have the opportunity of recording the views of Dr. Wilks on guarana and the other remedies which his special attention to the subject has led him to employ since the publication of his first paper. The opinion entertained by him regarding the value of cannabis Indica is shared by another of the writers in the report. Indian hemp seems deserving of a full trial.

"As regards the treatment of sick headache," says Dr. Wilks, "I have until late years been able to do little more than recommend to my patients the avoidance of all those circumstances which they know from experience would induce an attack. I allude, of course, to nervous headache, for I believe that this is almost the only form for which we are consulted; a temporary disturbance of the head arising

from various causes, requiring no medicine, or but a casual dose. During the last three or four years I have been able, with others in my profession, to do something more positive than preach hygienic principles to my patients, having in our possession three remedies which have been doing eminent service in this terrible complaint. In the first place, there is the bromide of potassium, which is so valuable a medicine in many cases of sick headache that it can scarcely be superseded by a better remedy. The patient, who is very often a gentleman, comes home with a splitting headache, fatigued and worried after a hard day's work; he takes fifteen or twenty grains of bromide of potassium, presently goes off to sleep in his easy chair, and wakes in an hour well. I have known this occur in so many instances, that I cannot hesitate in my belief as to the efficacy of this medicine. It is one which I always first employ, having seen such eminent advantages follow its use. I have known many patients declare, that the bromide was the first medicine they had taken in their lives which had had the slightest effect in relieving their headache.

"About two years ago, I commenced to use the cannabis Indica, and I have no hesitation in saying that in this drug we possess a most valuable remedy against headache. I have never given it in large doses with the object of counteracting the pain by producing an immediate effect, but have employed it in doses of a few drops three times a day, and continued for some weeks. In several cases where my patients were subject to constant headache, great benefit was experienced, several of them having written to say that they had got rid of their trouble, or it had been less frequent. I consider it superior to all other remedies in this respect that, if efficacious at all, it preserves the patient from his malady; whereas other medicines do little more than arrest the attacks when they have commenced. I have not given cannabis in the manner recommended by Dr. Williams (of Hayward's Heath), in the form of a dose of the extract daily.

"Thirdly, guarana has been introduced to our notice as a remedy for sick headache, and here, again, we have a very valuable addition to our *Pharmacopœia*. In many instances, especially those of ladies, I have had the most positive assurance given to me of the power of this drug in arresting headache, so that not the slightest doubt can be entertained of its immense value. A dose is usually taken when the headache is approaching; and if this is not quickly successful in arresting it, a second powder is swallowed; after an hour or so, if the remedy is to be useful, the headache has disappeared. I know of several cases in which the greatest enthusiasm is expressed by patients as to its merits. At the same time, I am constantly hearing of cases where it has failed. I am now trying it in smaller doses by daily administration.

"I feel certain that these three drugs—bromide of potassium, cannabis Indica, and guarana—constitute a most important addition to our nervine medicines, and that in them we have remedies against a terrible complaint which, a few years ago, constituted the opprobrium of medicine. I might say that I know of cases where galvanism has very speedily cured a pain in the head; and I can call to mind the case of a lady, where the application of the bisulphide of carbon invariably relieved the most severe headaches."—*Brit. Med. Journ.*, Dec. 21, 1872.

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*Ruptured Jejunum; Absence at First of Serious Symptoms.*—John R——, aged 32, brewer's man, was admitted into the London Hospital, under the care of Mr. Rivington, February 19, 1872. Patient was walking across a plank laid over a brewer's vat, when he missed his footing, and fell a distance of sixteen feet. When he came to the hospital he was examined by the house-surgeon, who was unable to detect any sign of a serious injury, and, consequently, gave him an out-patient's ticket. Later in the day he returned, complaining of pain in the chest, and also at the lower part of the belly. He was admitted as a case of contused chest. The patient was a very stout man, with much fat on his body, and it was therefore difficult to examine satisfactorily his ribs

and sternum. His water was drawn off, and it was like dark tea, without blood. He vomited once when he came in. Subsequently he had a disposition to vomit, but did not bring up anything. When seen about 5 o'clock, by Mr. Rivington, he did not exhibit the usual signs of the injury from which he was suffering; he did not complain of pain in the abdomen; he was not sick, and he was not in a state of collapse. In the course of the evening severer symptoms came on, and he died on the following morning at 11 A.M. At the post-mortem examination the jejunum was found ruptured near the duodenum, and the sternum was fractured.—*The Lancet*, Dec. 14, 1872.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Borax and the Nitrate of Potassa in the Loss of Voice from "Colds" in Public Speakers and Singers.*—Dr. John W. Corson, of Orange, N. J., states (*Medical Record*, Jan. 1, 1873)—

"1. That in sudden hoarseness or loss of voice in public speakers or singers, from 'colds,' relief for an hour or so, as by magic, may be often obtained by slowly dissolving and partially swallowing a lump of borax the size of a garden-pea, or about three or four grains, held in the mouth for ten minutes before speaking or singing. This produces a profuse secretion of saliva, or 'watering' of the mouth and throat. It probably restores the voice or *tone* to the dried vocal cords, just as 'wetting' brings back the missing notes to a flute when it is too dry.

"2. Such 'colds' may be frequently 'broken up' at the very commencement; and this restorative action of the borax to the voice may be materially aided by promptly taking, the evening previous to a public effort, dissolved in a glass of sweetened water, a piece of the nitrate of potassa or 'saltpetre' a little larger than a garden-pea, or about five grains, on going to bed, and covering with an extra blanket. The patient should keep warm next day. This both moistens the dry throat and further relieves the symptoms of 'cold' and slight blood-poisoning from suppressed perspiration, by re-opening the millions of pores of the skin more or less closed by cold.

"3. These remedies have the three recommendations of being easy to obtain, convenient to carry in travelling, and perfectly harmless.

"4. They are nearly or quite useless in the actual cure of long-continued chronic disease of the throat, or acute inflammation or 'tonsillitis,' both of which require other appropriate treatment."

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*Fluid Extract of Castanea Vesca in Pertussis.*—Dr. Thomas S. Davis gives in the *Medical Times* (Dec. 28, 1872) the results of the treatment of 15 cases, with this remedy. The first eleven cases had the characteristic whoop, the remainder had well-marked paroxysms, but not the full spasm, and they recovered without having it. In each case the violence of the spasm was reduced even more markedly than the number of the paroxysms. The castanea was continued for a week, after which, in a few cases, a simple expectorant was given. The nurse in charge, who had witnessed many epidemics of the disease, declared she had never seen medicine act like it.

This medicine is made from the beans of the common chestnut tree, castanea vesca, natural order *Cupuliferæ*. The preparation used was the fluid extract made by Mr. John M. Maisch, of Philadelphia (see *Amer. Journ. of Pharmacy*, Dec., 1871, p. 529). The dose is half a teaspoonful to a teaspoonful every three or four hours, for a child six years old.

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*Nitrite of Amyl in Spasmodic Asthma.*—Dr. James A. Duncan, of Toledo, Ohio, relates (*Michigan Univ. Med. Journ.*, Dec. 1872), three cases of spasmodic asthma promptly relieved by the inhalation of a few drops of the nitrite of amyl.

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*Medical College of the State of South Carolina.*—Dr. R.W. Gibbes, of Columbia, has been elected to the chair of Anatomy and Surgery in this institution made vacant by the resignation of Dr. Darby.

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*The Philadelphia Medical Register and Directory for* 1873.—We are happy to an-

nounce the publication of the volume for this year under the supervision of Dr. John H. Packard. In addition to the list of reputable practitioners of medicine in the city of Philadelphia, it also contains lists of the medical societies, medical schools, hospitals, dispensaries, charitable institutions, and miscellaneous lists of interest to the physician. It is a useful little volume of 308 duodecimo pages, and we trust that it will receive the support that it merits.

We regret that several inaccuracies have crept into the text. The library of the College of Physicians of Philadelphia, is stated to consist of "*nearly* 16,000 volumes," whereas the number is materially *over* that figure (see *Medical News* for January, p. 12). Again we read "over 3000 of these volumes have been given to the College by Dr. Samuel Lewis." This statement appears to have been copied from the Directory of 1868, and does injustice, unintentionally we are sure, to the liberality of the founder of the "Lewis Library," who is continually adding to his munificent gift, which now comprises between four and five thousand volumes.

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*Archives of Scientific and Practical Medicine.* Edited by Dr. Brown-Séquard, assisted by E. C. Seguin, M. D.—The first number of this journal has just been issued; it consists of one hundred octavo pages of tinted paper, neatly printed; and is announced to appear on the 15th of every month. The contents are varied and of unusual worth, and the name of its distinguished editor is a guarantee of the interest that will be attached to its pages.

We cordially welcome the appearance of our new *confrère* in the field of medical journalism.

## FOREIGN INTELLIGENCE.

*The Oxalate of Protoxide of Iron.*—At a recent meeting of the Académie de Médecine (*Bull. de l'Académie*, Oct. 12) M. Caventou delivered in his report on this substance, which had been laid before the Academy two years since by M. Girard. The reporter stated that the mode of preparation recommended by M. Girard is in no wise different from that usually employed in laboratories. Its therapeutical properties have been carefully tested by M. Hérard in cases of chlorosis and anæmia, and these prove to be worthy of attention, presenting a preparation of iron which, while proving efficacious, has no tendency to produce constipation. The preparation is almost insipid, is readily taken by patients, and easily borne by the stomach. Given in doses of from ten to twenty centigrammes per diem it increases the strength and cures chloro-anæmia as well as other good preparations of iron, while it establishes a peculiar claim by not causing constipation. Indeed, by raising the quantity to from thirty to fifty centigrammes, an aperient action is obtained. M. Caventou considers that this remedy should be indorsed with the recommendation of the Academy, which is necessary for the authorization of new remedies during the intervals that elapse between the editions of the Codex. —*Med. Times and Gaz.*, Nov. 23, 1872.

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*Abortive Treatment of Furunculi.*—As soon as there is perceived on any part of the body that characteristic redness, round in form and variable in size, with a culminating point in the centre, which, red at first, soon turns to a grayish-white, pour into a little saucer a thimbleful of camphorated alcohol; dip three fingers of the right hand into the liquid, and gently rub the part, especially the middle; moisten the fingers, and rub again in the same manner eight or ten times, for half a minute each time. After this friction, dry the place well, and anoint it lightly by the finger with camphorated olive oil, to prevent the evaporation of the alcohol. It is rare for a blind boil or furuncle, at the moment of lessening, to resist four applications of this kind. Often they decrease in inflammation, dry up and disappear, after only one application. When many applications are necessary, it is well to let a certain interval of time elapse between them—for example, to make them morning, midday, and evening.—*Brit. Med. Journal*, Dec. 21, 1872.

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*On a Means of Intensifying Cardiac Murmurs.*—At a meeting of the Clinical Society of London, held on December 13,

Dr. Vivian Poore explained a simple means of intensifying cardiac murmurs, which is likely to prove useful at the schools as an aid to clinical teaching. He illustrated the scheme by making his patient lie down upon a common mahogany table, placing a walking-stick vertically on the centre of his chest about the level of the third costal cartilage, and balancing upon the top of the stick the sounding-board of a guitar with the orifice downwards. His patient was the subject of an aortic diastolic bruit, and the arrangements made caused the murmurs to be distinctly audible to the members standing around at a distance of several feet from the patient.

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*Physiology of the Pneumogastric Nerves.*—As the result of a series of thirty-seven experiments carried on with electricity on dogs and pigeons, Prof. Masoin, of Louvain, has stated that there is a marked difference of action between the two pneumogastrics on the heart, and concludes that, for weakening and suspending the functions of the heart, the right nerve possesses a power far superior to that of the left one. The greater action of the right pneumogastric, adds M. Masoin, does not exert itself in any peculiar department of the heart, but in block as it were.—*The Lancet*, Dec. 7, 1872.

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*The Origin of Giant Cells.*—Schüppel, of Tubingen, has recently published in the *Archiv der Heilkunde* the results of a series of microscopical researches touching the origin of giant cells, which he had formerly found to exist in tubercle. His recent researches show that the origin of these cells is due to the transformation of vascular contents, or the organization of elementary granules into giant cells. They are, therefore, formed at the expense of the blood plasma, whether they take rise in the vessels themselves or out of them. The process is, therefore, a free formation of cells.—*Lancet*, Nov. 30, 1872.

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*Rheumatism in Whales.*—There is, unquestionably, a great deal of unknown and unrelieved suffering in the world. If want of sympathy and difficulty of finding relief add much to physical distress, it is sad to think of the new field of woe on the largest scale which Dr. Struthers has discovered in hitherto unexplored regions of pathology. In studying the osteology of whales, he has discovered that they are very liable to rheumatism. He has seen many examples of rheumatic ostitis in whales of different kinds. It has been said that animals are not subject to disease until they are brought into connection with man, but this fact contradicts the theory. It is the more remarkable, seeing that whales are less subject than man to variations of temperature. The cold-water treatment does not seem to be efficacious in the cure of the disease.—*Brit. Med. Journal*, Dec. 21, 1872.

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*Testing of Urine for Biliary Acids.*—M. Straburg (*Repertoire de Pharmacie*) uses the following method, which seems elegant, safe, and easy: 1. A bit of sugar is dissolved in the urine. 2. A bit of filtering paper is dipped in the urine and dried. 3. When the paper is dry, one or two drops of sulphuric acid are put upon the paper. If the urine contains biliary acids, the paper assumes a bright violet color on being examined with a strong light.—*The Lancet*, Nov. 30, 1872.

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*A Tale of a Nose.*—The readers of surgical works are doubtless familiar with those cases in which the nose is reported, after having been cut off, to have been successfully replaced—in one instance, after a dog had run away with it. An interesting example of the reparative power of nature in such an injury is recorded in last week's *Wiener Medizin. Wochensohr.* by Dr. Malfatti. On November 13, 1871, Lieutenant Preiser, while in barracks, had his nose cut off by a sabre. The wound passed through the middle of the cartilaginous part of the bridge of the nose, dividing the left ala along its posterior third, the septum through its middle, and the left ala two lines behind the anterior angle of the nostril. The piece cut off was taken up from the ground where it lay, cleaned with cold water, and reapplied, being secured in its place by means of sutures. A week after the injury, a dry scab began to form on the left ala,

and extended in the course of three days over nearly the whole nose. Granulations gradually formed, healing went on steadily, and on February 1, 1872, careful examination was required to detect any trace of the injury.—*Brit. Med. Journal*, Dec. 21, 1872.

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*Unhealthiness of Sewers.*—In our number for September last, p. 157, we copied a statement in regard to the exemption of men working in sewers from fever. We now see it stated (*Lancet*, Nov. 16, 1872) that Dr. Bateson, Medical Officer of Health for St. George's, Southwark, in his last Report draws attention to the extreme unhealthiness of men engaged in working in the sewers. We regret that it is not stated from what forms of disease they suffer.

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*Tincture of Chloride of Iron for Corns.*—Dr. C. Barber states (*Lyon Médicale*) that he has cured three cases of corns on the toes by the application of a drop of the tincture of chloride of iron applied on the corns night and morning. This application was continued for fifteen days in one case, when the corns from which the patient had suffered for thirty or forty years were entirely destroyed, and pressure on the part gave not the least uneasiness.

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*Deaths from Chloroform.*—In the *Brit. Med. Journ.* for Nov. 30, 1872, there is recorded the case of an intemperate hostler, aged 49, to whom chloroform was given for the purpose of painlessly resetting his fractured leg and dislocated ankle-joint. His heart suddenly stopped during the operation, and the usual restoratives were unavailing. A *post-mortem* revealed a diseased heart.

In the same journal for Dec. 14, there is reported the case of a labourer, aged 28, who died under chloroform administered for the purpose of painlessly amputating a thumb which had been crushed by an accident.

In the same journal for Dec. 28, still another case is recorded. A man, aged 35, was placed under the influence of chloroform at King's College Hospital by the chloroformist to the Hospital to have his leg examined by Mr. Henry Smith and necrosed bone removed, or the limb amputated at the thigh. He had inhaled chloroform for about five minutes, when signs of distress came on, in a minute or two more it was followed by a sudden cessation of the heart's action, a sudden gasping for breath, a brief struggle, and death. Restoratives were applied without avail.

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*Death from Hydrate of Chloral.*—A case of this is reported (*Med. Times and Gaz.*, Dec. 7, 1872) from the administration of two hundred grains prescribed by a druggist.

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*To Kill Lice.*—All kinds of lice and their nits may be got rid of *tuto, cito, et jucunde*, by washing with a simple decoction of stavesacre (*Delphinium staphisagria*) or with a lotion made with the bruised seeds in vinegar, or with the tincture, or by rubbing in a salve made with the seeds and four times their weight of lard very carefully beat together. The acetic solution and the tincture are the cleanliest and most agreeable preparations, but all are equally efficacious in destroying both the creatures and their eggs, and even in relieving the intolerable itching which their casual presence leaves behind on many sensitive skins. The alkaloid delphinia may be also employed—but possesses no advantage, except in the preparation of an ointment when for any reason that form of application should be desired.—*Edin. Med. Journal*, Nov. 1872.

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*Cholera in Russia.*—Over 80,000 persons are said to have died of cholera in Russia during the past year.

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*College of Surgeons of Dublin.*—Mr. Hargrave, in consequence of impaired health, has resigned the Professorship of Surgery in this school, and Mr. William Stokes has been elected his successor.

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*Paris Faculty of Medicine.*—Two of the three vacant chairs have been filled by the election of M. Charcot into that of Pathological Anatomy and of M. Léon le Fort into that of Operative Surgery.

*University of Vienna.*—Dr. Spath was installed as Rector of this University on the 18th November, and delivered his inaugural address, taking as his subject *Das Studiren der Frauen.* Recognizing the intellectual capacity of women, he remarked that they could not be rendered fit for the tedious study or for the difficult practice of medicine. They were not made by nature for these. He warned the ladies against the superficial knowledge through which they lost their womanhood and yet did not become like men; and he denied that women might be usefully employed in specially treating the diseases of women and children, for the lady-doctor must possess general medical knowledge beyond what was required for these purposes. The address was listened to with much attention, and at its close was highly applauded.—*Brit. Med. Journ.*, Nov. 30, 1872.

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*Professor Virchow.*—It is stated in the *Lancet* (October 26, 1872) that the freedom of the city of Bologna has been conferred upon Prof. Virchow "on account of the eminent services he has rendered to science."

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*Mr. Huxley.*—Mr. Huxley has recently been honoured by an election to the position of Lord Rector of the University of Aberdeen.

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*New Medical Journals.*—A new monthly journal, under the name of *Il Galvani*, is announced to be published this year at Urbino, in Italy. It is to be specially devoted to electro-therapeutics.

The first number of a new semi-monthly medical journal, called the *Irish Hospital Gazette*, was published on the 1st of January last. It, like the former *Dublin Hospital Gazette*, is to be mainly devoted to the cultivation of practical medicine and surgery.

The first number of a new London weekly, to be called *The Medical Record*, is advertised to be published on the 8th of January last. Its special object will be to supply an analysis of the contributions to medical literature contained in British and foreign periodical medical literature. We wish that the name chosen had been other than that of a well-known periodical published in New York.

*Revue des Sciences Médicales en France et a l'Étranger.*—This is the title of a new French quarterly journal announced by G. Masson, of Paris, to be published under the editorship of Dr. M. G. Hayem, of which the first number was issued on the 15th of January, 1873. It is intended to supply a want felt in France of a work like "The Half-Yearly Abstract" originated by Ranking, or the "Retrospect of Medicine" by Braithwaite, published in England, or of several similar works published in Germany.

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Obituary Record.—Died at Vauves, France, on Nov. 23, in the 78th year of his age, Dr. Felix Voisin, formerly principal physician to the Bicêtre Asylum. Dr. V. was a most distinguished alienist and the author of several works on mental diseases, the most remarkable of which is *Le Traitement intelligent de la Folie*, published in 1847.

—— on the 6th of December, in the 74th year of his age, M. Felix Archimede Pouchet, the distinguished zoologist of Rouen, and the well-known advocate of the theory of spontaneous generation. No fewer than eighty-three scientific works have proceeded from his pen, and his latest production was an able *résumé* of his views on heterogeny, published in a late number of the *Revue des deux Mondes.* The family ability is, we understand, perpetuated in his son, the author of several esteemed works in ethnology.

—— on December 22, aged 54, Holmes Coote, F.R.C.S., Senior Surgeon to and Lecturer on Surgery at St. Bartholomew's Hospital. Mr. Coote was a skilful anatomist, an active teacher, and a surgeon fertile in resources. He was a valuable contributor to Holmes's *System of Surgery*, and to journal literature. We regret to learn that he leaves a family with very restricted means. The cause of his death is stated to have been general paralysis.

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"I have endeavored to make the present edition of this work more deserving than its predecessors of the favor that has been accorded to them. In consequence of delays that have unavoidably occurred in the publication of the Sixth British Edition, time has been afforded me to add to this one several paragraphs which I trust will be found to increase the practical value of the work.

"LONDON, Oct. 1872."

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**HENRY C. LEA—Philadelphia.**

# THE MEDICAL NEWS AND LIBRARY.

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## LECTURES.

### *The Relative Frequency of Disease between the Right and Left Sides of the Heart—Degeneration of the Heart; its Causes and Means of Avoidance.*

By CORNELIUS BLACK, M.D. Lond., M.R.C.P., Corresponding Fellow of the Imperial Soc. of Phys. of Vienna, etc. etc. (Continued from page 21.)

Heart of newly hatched trout—How affected by the negation of oxygen and an increase of carbonic acid—Influence of carbonic acid upon the contractile fibre of the heart—Effects on the human heart of pre-breathed air—Defective ventilation a frequent cause of sudden death in heart disease. Importance of pure air in cardiac degeneration.

THE object of my last communication was to show that the relative frequency of disease between the two sides of the heart depended, as a rule, upon age; that the left side of the heart was the one to suffer before the age of forty, the right side of the heart after that age. It was also shown that diseases of the left side of the heart are generally the result of inflammatory action; diseases of the right side of the heart, of tissue-degeneration, or of mere mechanical influences, as of backward pressure of blood upon the right cavities of the heart from obstruction to its flow through the branches of the pulmonary artery.

It was further stated that, according to the ordinary law of life, tissue-degeneration, or natural decay, usually begins at the age of forty; that, with its advent, the left side of the heart becomes less

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prone to inflammatory disease, and approaches more and more closely in its tendencies to the diseases of the right side of the heart; and that the degenerative tendency of the latter is, after this age, greatly influenced by the three great vital functions—the action of the brain and nervous system, respiration, and circulation.

It was thus shown that, to maintain the heart's structures in as healthy and sound a condition as they could possibly be maintained under the law of natural decay, these vital functions must neither be overworked nor fall short of their necessary duty—that, in fact, regular, natural, action is their law of life.

I showed the effect of impure air in promoting the degenerative tendency in the structures of the heart, and especially in those of the right side of the heart, after the age of forty. I was thus led to a passing consideration of the baneful influence produced upon the heart by badly-ventilated houses, schools, manufactories, pits, theatres, under-ground railways, and all places of a similar character.

To this point I return, to show the influence of an increasing quantity of carbonic acid in the air respired upon the contractility of the muscular fibres of the heart.

I take for my example the newly hatched trout. During the winters of 1869–70 and 1870–71, I hatched some thousands of this fish, many of which I daily submitted to microscopic examination. The result of my investigations, in reference to the action of the heart and to the influence upon it of a decreasing quantity of oxygen and an increasing quantity of carbonic acid in the water in which the fish was confined, shows—

That, on placing the fish in a glass trough containing a quantity of water, the heart is seen, under the microscope, to be affected in the following manner:—

In the first few moments of examination the venous blood, collected by the veins from the head, back, and yelk-bag (the first two of which unite to form a bulbous vessel into which the third opens) is seen to be projected with considerable force and rapidity into the upper (auricle) of the two cavities of which the heart is composed, and thence as instantaneously into the lower (ventricle) cavity, which contracts with equal rapidity, and forces the blood into the branchial artery, which conveys it to the gills. The projection of the blood into the auricle, its passage into the ventricle, and its expulsion therefrom, are but the work of an instant. As the blood enters the auricle both it and the ventricle seem to anticipate the charge of blood; but especially is this the case with the ventricle. Before the blood well touches the valve which guards the entrance from auricle to ventricle, the latter is observed to shorten its longitudinal diameter, to visibly meet, as it were, the coming charge of blood from the auricle, and to force it instantly into the branchial artery. There is no delay whatever of the blood in the auricle or ventricle. It is shot in a straight line from the vena cava through the auricle and the auriculo-ventricular valve, caught by the contracting ventricle, and deflected and forced, without a moment's delay, into the branchial artery.

From these observations it was evident that the contraction of the heart was not excited by the distension of its cavities, but that it was induced by the mere impingement of the blood upon its lining membrane. In contracting the ventricle was seen to roll about one-third upon its axis, by which a portion of that part of it which was previously out of sight was brought into view. As soon as it had delivered its blood into the branchial artery, it relaxed, and increased again its longitudinal diameter, recoiling from systole with an energy and a rapidity equal to those of its contraction.

In three or four minutes the heart is observed to contract both less quickly and less energetically. A very short time after this the blood can be seen gently pouring into the auricle, and thence into the ventricle, which latter now allows itself to be about one-fourth filled before it contracts. It now expels its blood, and again dilates; but its dilatation, like its contraction, is not so instantaneous as it was when first observed under the micro-

scope. In a short time longer the sensibility of the heart is greatly diminished, for the blood is seen to be accumulating in both the auricle and ventricle, but especially in the former, from both of which cavities it is now only partly expelled by the contraction of the heart.

At length, just before death, the blood is seen to flow from the auricle into the ventricle, thence into the branchial artery and along it, the heart being passive during this time, and only now and then, at long intervals, manifesting a very slight and partial contraction. During the whole of this time the blood is coagulating more and more in the auricle and ventricle, but especially in the former; and when, at length, the heart has ceased to beat, the auricle and the vena cava, opening into it, are fully distended, whilst the ventricle is only partly distended with black-red blood. In the last moments of life, after the heart has ceased to beat, the branchial artery is seen to be pushing forward its slender current of blood, and to become at length quite empty and transparent.

Here, then, as the oxygen dissolved in the water in which the fish is confined becomes exhausted, and as the carbonic acid increases, the sensibility and contractility of the heart are diminished, and at length entirely destroyed. The negation of oxygen, and the increase of carbonic acid, have culminated in the death of the fish.

*Precisely the same effect is produced upon the human heart by an accumulation of carbonic acid in the air respired.*

In the ordinary condition of the atmosphere, in which carbonic acid does not exceed one part in a thousand parts of that medium, its effects upon the heart are inappreciable. When, however, the carbonic acid has accumulated to the extent of one per cent. of the air respired, it begins to produce a slight feeling of faintness, and some degree of uneasiness across the brow. At 2 per cent. the heart's action is quickened, the sense of faintness is greater, there is slight giddiness, with heaviness and constriction of the head, together with nausea. At 3 per cent. all these symptoms are increased There are vertigo, fluttering of the heart, nausea and sickness, followed by an overwhelming sense of muscular prostration. At this moment the contractions of the heart become very feeble, the skin relaxes, and is bedewed with a cool, clammy perspiration. These symptoms deepen with the increasing quantity of carbonic acid in the air respired until the utmost limit of toleration is reached, beyond which life can no longer be maintained. At this stage lethargy supervenes; and, at the moment of its occurrence, the heart begins to beat less frequently, and much less powerfully than before. This condition is the parallel of that observed in the young trout, when the blood begins to accumulate and to coagulate in the auricle and ventricle, and when the heart's sensibility and contractility are reduced in the greatest degree.

From these effects it is certain that confinement to an atmosphere impregnated with carbonic acid, even to the extent of one per cent. only, quickly deranges the function of the heart, and ultimately deteriorates the tissues themselves of that organ.

The greater the percentage of carbonic acid in the air respired, the more quickly and the more profoundly are these effects produced. The constant breathing of air containing one per cent. only of carbonic acid proves fatal to life; but if it is respired for a short time only, functional disturbance alone is then and there produced. *It is, however, certain that in this functional disturbance lie the germs of organic mischief, and that frequent repetition of the cause will undoubtedly end in organic disease. Hence the impure atmosphere of the bedrooms of the poor, and, indeed, of many of the middle class, proves a sharp spur to the degenerative tendency manifested by the heart, and especially by the right side of the heart, after the age of forty.* Such bedrooms are generally small in their superficial area, low-pitched, and often lighted by a diminutive window, which at night is kept constantly closed; and having a door which opens to the interior of the house, but which is also closed during the occupation of the rooms. Nay, to prevent the slightest admission of fresh air,

the crevices of both window and door are most carefully stopped; and, to render the matter still worse, a fire is not unfrequently kept burning during the winter nights.

What must be the effect produced upon the air of such rooms under the conditions named? I take, for example, an average-sized bedroom in the cottages of the poor—say a room twelve feet long, ten feet wide, and eight feet high. This gives a cubical space of 960 feet, which is not more than half the cubical space allowed each patient in our best arranged hospitals. In this room, with its diminutive window and door constantly closed, three, four, and frequently a greater number of persons pass the night of eight or ten hours' duration. No provision has been made for the admission of fresh air—none for the escape of the carbonic acid exhaled during respiration. What little provision did exist in the crevices formed by the badly-fitting door and window has been carefully abrogated by sand-bags, rolls of rags, and stuffing of every description. Thus the air of the room becomes poisoned with carbonic acid, and in this condition it is breathed and re-breathed, to the manifest injury of the heart.

A simple calculation will enable us, if not to determine with exactitude, at least to approximate to the amount of carbonic acid exhaled by each sleeper, and consequently to the degree of vitiation which the air of the apartment undergoes. I fix the number of respirations at its minimum—14 per minute; the quantity of air exhaled at each expiration at 20 cubic inches; the quantity of carbonic acid contained in the expired air at 4 per cent.; and the duration of the night at 8 hours. Hence, $14 \times 20 \times 8 \times 60 = 134{,}400$ cubic inches, or 77.77 cubic feet of air expired by each sleeper during the night of eight hours. This expired air contains 4 per cent. of carbonic acid. ∴ 100 : 77.77 :: 4 = 3.11 cubic feet of carbonic acid exhaled by each sleeper during the night. Suppose the number of sleepers occupying the bedroom to be four, this will give $3.11 \times 4 = 12.44$ cubic feet as the quantity of carbonic acid which is exhaled by the four sleepers during the eight hours of night. The room itself contains 960 cubic feet of air, and through this 12.44 cubic feet of carbonic acid would have been diffused by the termination of the night. It, therefore, follows that, if no fresh air entered the room, and if in consequence the carbonic acid had no means of escape, the air of the apartment would, at the end of the eight hours of night, contain 1.29 per cent. of this gas—a quantity sufficient to produce serious results.

This statement, however, does not represent all the facts of the case. It must be remembered that the oxygen, contained in the air of the room, would be constantly undergoing reduction by respiration during the night. If the quantity thus consumed were determined from the quantity of carbonic acid exhaled, allowing for the fact that 15 per cent. more oxygen is taken into the blood than is contained in the carbonic acid of the air expired, it will be found that from one-third to one-half of the oxygen originally contained in the air of the room would have been consumed by the end of the night. This reduction in the quantity of oxygen, and the great increase of carbonic acid, would affect the body in two ways—firstly, by a deficiency of oxygen, and secondly, by an excess of carbonic acid in the air respired. Hence the reduction of the one and the increase of the other would render the air far more injurious than if only one of these changes in its constitution had taken place.

The actual result is not, however, in strict accordance with this calculation, because fresh air, although in limited quantity, does find its way into the room, and carbonic acid does, to a limited extent, find its way out. These, therefore, would modify the constitution of the air of the room at the close of night; but they would still leave it with an excess of carbonic acid injurious to life.

It is found that when air, moderately impregnated with carbonic acid, is inspired, it greatly impedes the exhalation of more from the lungs; and that the greatest quantity of carbonic acid which exists in pre-breathed air never exceeds

10 per cent. It is much to be feared that to this degree of vitiation the air of the bedrooms of the poor, and of others not unfrequently, rises by the too prevalent system of excluding fresh air, and by the frequent absence of provision for the escape of that which has already passed through the lungs.

Can it then be a matter of surprise that death from diseased heart should so often occur during the night?

*In thousands of instances of cardiac disease life is thus sacrificed, where, had but proper ventilation of the bedrooms been observed, the subjects of such disease might, despite the cardiac mischief, have continued to live for an indefinite time.*

It has frequently been my duty, during a practice of nearly thirty years in the midst of a large community prone by the habits and particular avocations of the people to heart disease, to investigate cases of "found dead" in bed, and I have often been compelled to refer the immediate cause of death to the effect of carbonic acid liberated by respiration and confined to the apartment, in destroying the sensibility and contractility of the heart, rather than to the direct influence of the diseased heart itself.

I remember that on one occasion I was summoned to a case which had occurred in a bedroom 15 feet long, 12 feet wide, and 8 feet high. In this room, with the door and window closed, no fewer than twenty persons slept night after night! Can any one doubt that the air of such a room would be charged to excess with carbonic acid exhaled by respiration? Those who perished in this manner were beyond the age of forty; and, in every instance examined, the right side of the heart was either primarily affected by tissue-degeneration, or by disease consecutive to mischief in the left side of the heart and lungs.

Often, indeed, in the dwellings of the middle and higher classes of society the provisions for ventilating both their bedrooms and their day-rooms are miserably inadequate to preserve health. The consequence is that cardiac disease is promoted to an inconceivable extent. *There is no other disease in which the demand for cold, fresh air, is so urgently pressed by the patient as in cardiac disease. There is none in which a constant supply of pure air is more needed—none in which it is more grateful to the patient, or in which it has a more immediately beneficial effect.* At all times and seasons—in the depth of winter—by day and by night—a patient suffering from a paroxysm of cardiac asthma will hurry to the open door or window, and there, with his body hanging half out, will remain, with scarcely any vestments upon him, breathing the cold air until the paroxysm has ceased. Ought not this urgent, this powerful supplication of nature to teach us the importance of ventilation, and of a full supply of fresh air in the treatment of heart disease?

*I hesitate not to say that free ventilation —the free admission of pure air into the apartment by day and by night—is one of the most important remedial measures which can be adopted in the treatment of this disease.*

Where this means is defective, but where, nevertheless, the vitiation of the air of the bedroom does not exceed 1 per cent. of carbonic acid, a sensible effect is produced upon those who have slept within its influence. They complain, on leaving their bed, of weakness; their limbs tremble; they feel somewhat giddy, and their head feels heavy, or it aches. The least effort disturbs the heart's action, which is somewhat quick and feeble; their countenance is pale; the lips are not unfrequently somewhat blue; and the tongue is covered with a thin, whitish, and somewhat slimy fur. The appetite is in abeyance; there is a feeling of nausea, and the first evacuation is generally dark in color.

What is the pathological condition of such patients at this moment? Simply this: The blood contains an excess of carbonic acid, which, circulating with the blood through every organ, disturbs the natural action of every organ, blunting its sensibility, vitiating its particular function, and interfering with those molecular changes which constitute healthy nutrition.

A person thus affected does not usually

die. The body, removed to a pure atmosphere, begins at once to excrete the carbonic acid by the lungs, the liver, the skin, the kidneys, and the bowels, and in the course of a few hours the more visible manifestations of its baneful effects have passed away. It, however, often happens that a sense of weariness and muscular debility is felt for days afterwards. Night, too, frequently places such subjects in the same condition as before. The same bedroom is occupied; the same inadequate means of ventilation continue; the same accumulation of carbonic acid takes place; and the same effects upon the bodily organs are repeated. Blood charged with an excess of carbonic acid again pervades every tissue of the heart, diminishing its vitality, lowering its sensibility, and assimilating its nutrition to that of the reptilian heart. But the low character of the nutrition of the reptilian heart does not accord with the comparatively quick circulation, rapid nutrition, vital power, and energy of action required by the human heart. The one cannot be substituted for the other. In man the change results in disease where disease does not exist—aggravates disease where it is already present.

To point out the particular changes which are thus produced in the tissues of the human heart will form the subject of my next communication.—*The Lancet*, Sept. 7, 1872.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Remarks on Excision of the Shoulder-joint and of the Wrist-joint.* By Prof. ERICHSEN, of King's College Hospital. —Excision of a joint may be required in disease or compound injury of the articular structures; but the following remarks will apply only to resection of diseased joints, and in the first place to that of the shoulder-joint.

About May, 1870, a healthy boy, aged fourteen, struck his left shoulder against the corner of a wall, and, although nothing was noticed for some months, inflammation supervened, and about nine months after the receipt of the injury a large abscess formed behind the shoulder. The abscess was opened, but nothing but blood escaped till the fourth day, when pus was freely discharged. A sinus leading down to carious bone resulted. On September 17th, 1872, the boy was admitted into the hospital, and was examined by Mr. Heath, who detected dead bone at the upper part of the humerus, and advised an operation. On October 2d, the boy being under the influence of chloroform, Mr. Erichsen examined the joint with a probe, and found extensive disease of the scapula as well as of the humerus. A longitudinal incision was made from the sinus (which was just behind the posterior edge of the deltoid) through the deltoid muscle, and the joint exposed. The head of the bone was then sawn off, and the dead bone in and around the glenoid cavity gouged out. The humerus was then replaced, and the wound closed with wire sutures. The boy progressed without a bad symptom, and by the 21st of the same month was nearly well. On the 28th passive motion was commenced; and on November 9th the boy could move the limb without difficulty or pain. The wound was nearly closed, although there was a considerable discharge from the old sinus.

In the healthy shoulder-joint there are five movements—namely, flexion, extension, adduction, abduction, and rotation, and it is desirable to preserve as many of these as possible, although some are necessarily destroyed. The joint in this case was incurably diseased, as the articular structures were deeply affected, and death might have resulted from hectic; and if the joint had not been excised, amputation of the limb, with excision of part of the scapula, would have been necessary. The object of the operation was, therefore, to remove the diseased structure, and thus probably to save the patient's life, and to save the limb by removing only the diseased joint. In the upper limb it is all-important to preserve the movements of the hand, for without the hand the upper limb is practically useless, but leave the hand and it matters little how much of the upper portion of the limb be removed. Now, excision of the shoulder-joint leaves the movements

of the elbow- and wrist-joints free; still the limb is crippled. To what extent? What movements are destroyed? Much depends on the kind of operation performed. The older operation was to make an anterior flap, and thus to cut through the insertion of the deltoid muscle; but the more modern operation does not interfere with the insertion of this muscle, as the incision is made in the course of the fibres of the muscle. But all the muscles attached to the tuberosities are sacrificed, as the line of section must be through the surgical neck of the bone, the disease rarely stopping at the anatomical neck. There will, therefore, be a loss of the overhand movements, while the underhand movements will remain practically perfect. This leaves a useful limb, for the overhand movements are rarely required, and for nearly all ordinary occupations the underhand movements are sufficient. The after-treatment consists in keeping the limb at rest for three or four weeks, and then exercising passive motion. The fistulous opening may continue to discharge for a long time, as a large cavity is left, which may take months or even a year to close.

The old operation for excision of the wrist-joint consisted in exposing the joint by making a semilunar dorsal flap and cutting through the extensor tendons of the wrist and hand. The modern operation, which was first proposed by Professor Lister, preserves both the flexor and extensor tendons. The movements of the wrist are those of flexion and extension, and for this purpose there are five sets of muscles—viz., those of the thumb, the extensors of the fingers, the flexors of the fingers, the extensors of the wrist, and, lastly, the flexors of the wrist. In Lister's operation the extensors and flexors of the thumb and the extensors and flexors of the fingers are preserved, but the extensors of the wrist are necessarily divided; the flexor carpi ulnaris is left attached to the pisiform bone, and the flexor carpi radialis usually escapes from being inserted low down into the second metacarpal bone. The only muscles therefore that are necessarily divided are the extensors of the wrist. The diseased carpus, with the heads of the metacarpal bones, and the end of the radius and ulna, are removed, care being taken to leave the radius and ulna, especially the styloid process, as long as possible. By this means the tendency to displacement to the ulnar side is to a great extent counteracted. The object is to get anchylosis at the wrist, but to preserve the movements of the fingers. With these movements the patient can write and perform many useful acts. Although the details are very complicated, the broad principle of the operation is to save the movements of the thumb and fingers, and thus to gain a useful hand. The only vessels in danger in this operation are the radial and deep palmar arch, and the latter is best avoided by not cutting below the bases of the metacarpal bones.—*Lancet*, Jan. 11, 1873.

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### HOSPITAL NOTES AND GLEANINGS.

*Long-standing Diarrhœa cured by the Surgical Treatment of an Ulcer of the Rectum.*—Mr. ANNANDALE reports (*Brit. Med. Journ.*, Dec. 21, 1872) a case of persistent diarrhœa which had resisted many remedies. On making an examination Mr. A. ascertained the presence of an ulcer on the posterior wall of the rectum about an inch above the anal orifice. A free incision was made through the sphincter and base of the ulcer, which was followed by marked improvement. He subsequently made a second incision, and this was followed by a cure of the disease.

Mr. A. remarks "this case is an illustrative example of a class of cases which are by no means uncommon, but the true nature of which is not always determined, for it is not the first one of the kind which has come under my surgical care after medicine has failed to afford relief. It is important to note that in such cases the operation is not always followed by immediate relief to the diarrhœa, but that some weeks may elapse before improvement occurs. In another case of the kind under my care, it was several months before an improvement in the symptoms was observed. I have also noticed that the first

effect of the operation in these cases may be to cause a temporary cessation of the diarrhœa; but this result is not permanent, the final relief only taking place after some weeks or months.

"It will not, I think, be doubted that the ulcer of the rectum in the case just reported was the cause of the dysenteric symptoms, for its removal gave the relief which careful medical treatment had failed to afford. The patient, a gentleman of high standing in the Indian medical service, has himself no doubt in regard to this point, and will, I feel sure, bear testimony as to the value of surgical treatment in cases such as his own."

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*Cellulitis of the right side of the Chest; Pyœmia with Pustular Eruption; Death.*—This case of pyæmia is interesting in the fact that, unless we regard the cellulitis as standing in causal relation to the subsequent phenomena, it was not preceded, as far as could be ascertained, by any suppurative process. Although this is of rare occurrence, there is sufficient evidence to show that it does sometimes take place. In such a case it is difficult to explain the origin of the blood-poisoning. Did it arise from the old softened clot in the axillary vein?—or was this also secondary to disease of the vein or to a morbid condition of the blood? The secondary affections may in great part be accounted for by the embolic theory; but this seems to be insufficient to explain all cases. It is highly probable that, in some instances at least, they are the result of a local stagnation of the poisoned blood.

W. G. S.——, aged twenty-nine, was admitted into St. Thomas's Hospital under the care of Dr. Bristowe, on the 16th of July. His illness began two weeks before, with sudden pain in the right side, extending round to the back, and with "catchings" in respiration. No history of any injury except a strain. On admission there was a hard, red, brawny swelling on the right side below the axilla, very tender, but presenting no signs of "pointing," as of an abscess. Breath-sounds healthy. Ordered a linseed-meal poultice to be applied over the swelling.

July 20th.—Patient transferred to the surgical wards, under the care of Mr. Simon.

26th.—Much the same till to-day, when two small specks of suppuration appeared below the axilla, but no distinct "pointing." Free incisions were made and some pus evacuated. Other swellings were noticed on the right thigh and left calf; these were also incised, and thick pus escaped. A small subcutaneous collection of pus over the left shin was also cut down upon and evacuated. Temperature 104·6°; pulse 120; no rigours, but sweatings. Ordered eight ounces of wine, eggs, and a saline mixture.

29th.—Temperature 105.4°; pulse 140; skin dry and hot; many inflamed spots in the skin scattered over the whole body, in some places resembling typhoid spots; side brawny and covered with vesications; frequent muscular twitchings, but no actual rigours; bowels loose yesterday morning; marked ptosis of left eyelid.

30th.—Distinct and numerous pustules over the surface of the body, some of them not unlike those of smallpox; free incisions made into the sloughy surface of the chest; temperature 103.6°.

Aug. 1st.—Died at noon. Consciousness remained to the last.

*Autopsy twenty-six hours after death.* (Notes by Dr. Payne.) Skin covered with a pustular eruption, some of the pustules being about the size of those seen in smallpox, but the majority three or four times larger, and of very irregular shape, the greater number being surrounded by a vascular injection. The contents of some were yellow, others were stained with blood, or even quite black. On opening the pustules, the contents in some cases readily escaped, and the walls collapsed; in others the contents were thick and pasty, and did not turn out readily; and in a few cases a rough hemorrhagic surface showed itself. The elevated epidermis formed in all a simple cavity, not one being divided into partitions. There was no ulceration except on the face; but on the upper lip, and along the left ala of the nose, there was a deep suppuration, with loss of substance, involving to a considerable extent the sub-

cutaneous tissue. The eruption was most copious on the face and scalp, and more copious on the limbs than on the trunk; none on the palms or soles. There was purulent infiltration among the muscles, from the clavicle to the left rib on the right side, the pus surrounding the ribs, and stripping off the periosteum in places, although there was no accumulation under it. There was, however, no necrosis of the bone, or anything to show that the bone or periosteum originated the inflammation. The pleura was not perforated, but the sub-pleural tissue was œdematous and suppurating. In the portion of the axillary vein beneath the pectoral muscles was an old mottled clot, which easily crumbled under the finger, and was softened in the centre, thus forming a complete tube. The clot terminated abruptly, and did not extend into the brachial, or jugular, or superior cava veins. In the upper lobe of the right lung, beneath the pleura, were several small consolidated masses, varying in size from that of a pea to that of a hazel-nut, and softening in the centre. The pleuritic surface over these masses was injected. The lower lobe was intensely congested and œdematous. In the left upper lobe were three or four masses similar to those found in the right lung, and the condition of the lower lobe on this side closely resembled that of the right lower lobe. None of the other viscera presented any morbid change.—*Lancet*, Nov. 30, 1872.

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*Symptoms of Abdominal Obstruction coming on suddenly; Abdominal Taxis; Recovery.*—A man, aged 49, was admitted into the London Hospital, under the care of Mr. Hutchinson, at 7 P.M. on November 29, almost in collapse, with extreme abdominal pain, well characterized stercoraceous vomiting, and constipation. Careful examination proved the absence of any kind of hernia, and there was no local swelling or tenderness of abdomen to aid in the formation of an accurate diagnosis. The history was in favour of some sudden displacement or knotting of intestine. At 5 A.M. on the morning of the day before admission, as he was walking hastily across the street, his foot slipped on the curb, and he immediately felt acute pain in the epigastrium. For about half an hour he took no notice of it, but within an hour of the occurrence he was so bad as to require help from a neighbouring public house, where he had been for some brandy, to his home. In a short time vomiting began, and continued at frequent intervals till relieved by the operation. Mr. Tay had put him under chloroform, injected water into the rectum, vigorously kneaded the abdomen, and, placing the patient's feet uppermost, had him well shaken. It was found that several hand-basinfuls of water could be injected and retained before the kneading was begun, and his abdomen was visibly distended by the fluid, proving that there was no obstruction in the large intestines. Relief speedily followed these measures, and two hours later, when Mr. Hutchinson and Mr. Tay both saw him, the patient expressed himself as almost well and quite free from pain, so that there was no longer any need to entertain the question of an exploratory abdominal section. He only vomited once after the operation. The enema was soon returned, and next day he had a free fecal evacuation. To-day (December 2) he is nearly well.—*Med. Times and Gaz.*, Dec. 14, 1872.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Testimonial to Dr. Druitt.*—Our readers, we are sure, will regret to learn that Dr. Druitt, the author of the favourite text-book on Surgery, who has devoted his life to the service of the public and the profession, has been obliged by failing health to abandon practice and seek repose in a warmer climate. The leading members of the profession in London have organized a committee to raise funds for a testimonial in recognition of his labours, and they call upon their brethren in America to aid in the good work.

Dr. Druitt's "Principles and Practice of Modern Surgery" has been the means of instruction to so many of our professional men during the last thirty years that we cannot doubt that this appeal will be liberally responded to. Subscrip-

tions will be received and transmitted if addressed to Dr. George C. Shattuck, No. 6 Newbury St., Boston; John H. Swift, Esq., No. 56 W. 21st St., New York; or to Henry C. Lea, Nos. 706 and 708 Sansom St., Philadelphia.

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*Poisoning by Strychnia, successfully treated with Hydrate of Chloral.* By S. S. TURNER, M.D., of Grand River, Dakota.

At noon, April 28, 1872, I was called to see L., æt. 40, who was reported to have been poisoned with strychnia, by wife—cause, jealousy. I found strychnia on the premises, and learned that during the forenoon—time unknown—the wife brought her husband a lunch of bread and broiled pork; that the husband, noticing a bitter and unusual taste about the pork, ate only one mouthful, and threw the remainder into the fire, which left me no means of estimating the quantity of the drug swallowed.

All the usual symptoms ascribed to poisoning by strychnia were present, and well marked. Gave chloral gr. xxx. In about thirty minutes there was marked abatement in the severity of the convulsions, and improvement in vision. In thirty minutes more a violent convulsion ensued, and fifteen grains of chloral were given with the effect, in a short time, of inducing freedom from convulsions, which lasted. Half an hour afterwards convulsion again returning, I gave chloral gr. xxx. Relief followed quickly, and the patient remained tranquil for three hours, when, slight spasm recurring, another dose, gr. xxx, of the drug was administered.

No further convulsion occurred. The patient slept all night, and on the following day complained only of extreme muscular soreness, which was mitigated by chloral hydrate in reduced quantity.

Though I had frequently employed chloral for the relief of pain and insomnia, with satisfactory result, I was not prepared for the rapidity with which the drug manifested its influence over clonic spasm in the case under consideration.

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*On the Art of Depilating.*—Dr. M. H. HENRY states (*Am. Practitioner*, Feb. 1873) that "experience has forced me to believe that the failures so often attributed to the depilating process have been due to a great extent to the want of skill on the part of the operator, and a reasonable knowledge of the main features of the art which are essential to the successful performance of any delicate surgical operation.

"As a preparatory step, and before commencing depilation, the hairs are cut, not leaving them longer than a quarter of an inch above the skin. I am then in the habit of rubbing, very gently indeed, a little oil of cade and olive oil, or the latter alone, over the diseased hairs. This serves the double purpose of destroying the fungi lodged in and about the hair-surface by acting as a parasiticide; it lessens at the same time the sensibility of the scalp and softens the hair bulbs, and in this way facilitates the removal of the diseased hairs.

"In depilating the diseased surface should be stretched between the first finger and thumb of the left hand, and the forceps held in the right hand in about the same manner as pursued in using the pen. If conducted in this way, little fatigue will be felt in the course of the ordinary sittings. Keep the forceps perfectly clean; do not permit any *débris* to collect round the blades. Be careful to extract the hair in the direction of its growth, thus avoiding the chance of its breaking off, leaving the fungus beneath the skin to again act as a source of evil. Never attempt to extract more than five or six hairs at one time."

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*Charleston Medical Journal.*—We are happy to learn of the revival of this valued periodical, under the editorial supervision of Drs. F. Peyre Porcher and R. A. Kinloch. The first number is announced to appear on the first of April, and quarterly thereafter. Its list of distinguished collaborators gives promise that the journal will sustain the reputation attached to its name.

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*Northern Wisconsin Hospital for the Insane.*—This institution, located at Oshkosh, has been so fortunate as to secure

the services as superintendent of Dr. Walter Kempster, late second assistant physician of the New York State Lunatic Asylum at Utica.

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Obituary Record.—Died at New Orleans, on the 6th of December, 1872, in the 66th year of his age, Warren Stone, M.D., a distinguished surgeon of Louisiana.

—— at Ogdensburg, N. Y., February 1, 1873, aged 71, Hon. Socrates Norton Sherman, M.D., an eminent physician and citizen of Ogdensburg, and formerly representative in Congress of that district.

## FOREIGN INTELLIGENCE.

*Fibro-cystic Uterine Tumours.*—At a late meeting of the Academy of Medicine at Paris, M. Demarquay discussed the advisability of gastrotomy in cases of fibro-cystic tumours of the uterus. In twenty operations he had had eight cures and twelve deaths; the mortality being greater than that caused by ablation of ovarian cysts. The cause of death in these cases was almost always due to hemorrhage, peritonitis, phlebitis, etc. He went on to say that until 1862 the majority of operations of this kind were performed in consequence of errors of diagnosis; surgeons, believing they had to operate on ovarian cysts, unexpectedly found fibro-cystic tumours of the uterus, which the science of diagnosis had not then enabled them clearly to distinguish. Since 1862, surgeons, aware of this cause of error, have practised partial or total ablation of the uterus. An incomplete table of the results of this operation, since 1866, includes forty-two cases of partial uterotomy, of which thirty-three died and nine were cured. The cause of death was generally hemorrhage and peritonitis. Lately, more fortunate results of this operation have been published by Spencer Wells, Kœberlé, and Péan. In spite of these successes, M. Boinet rejects the operation and doubts the results obtained, and in this opinion M. Demarquay agrees. In fact, fibro-cystic tumours of the uterus can remain long stationary, ending even by becoming atrophied; in one word, they are compatible with life, which cannot be said for ovarian cysts. It is exceptional to see tumours develop to such a size as to endanger life. The ablation of an uterine tumour, whatever its size, is always a serious undertaking, unless there be a long and narrow pedicle. Even in the case where the life of the patient is menaced, M. Demarquay agrees with M. Boinet in rejecting the operation, for the following reasons: 1. The uncertainty of being able to conclude the operation; 2. The chances of fatal hemorrhage; 3. The length of the operation; 4. The serious consequences which ensue—nervous shock, consecutive peritonitis, secondary hemorrhage, and death. Those cases of success obtained by various surgeons, amongst others by Kœberlé, Péan, etc., prove nothing. Conscientious statistics should be kept of a certain number of well-attested facts.—*Brit. Med. Journ.*, Jan. 4, 1873.

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*Four Cases of Constitutional Syphilis cured by Hypodermic Injections of Calomel.*—Dr. Ulisse Bonadei reports (*Giornale Italiano delle Malattie Veneræ e della Pelle*, Dec. 1872) four cases treated in the Maggiore Hospital of Cremona, and which presented unmistakable and more or less grave symptoms of constitutional syphilis. The results obtained by means of the hypodermic use of calomel were very brilliant and rapid, and it is stated that sixteen months after the cure no recurrence of the syphilitic manifestations had supervened.

In the same number of the journal three similar cases as above are recorded by Dr. Sante Pico. They were observed in the Civil Dispensary at Mantua, and were as successful as the preceding four. —*The Lancet*, Jan. 18, 1873.

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*Nitric Acid in the Treatment of Hooping-cough.*—Mr. Berry states (*Med. Times and Gaz.*, Feb. 8, 1873), that he has found dilute nitric acid, in doses of from five to fifteen minims—according to age—with simple syrup, given every three or four hours, to alleviate the cough and spasm, and apparently cut short the disease. In

all cases, at the same time, Mr. B. has paid attention to the state of the digestive organs, and in such cases as required it he gave an aperient combined with a laxative.

—

*Cleansing of Wounds.*—Mr. Callender brought before the notice of the Clinical Society of London the arrangement adopted in his wards at St. Bartholomew's for the use of camel-hair brushes for the cleansing of wounds. He pointed out the importance of gentleness in their dressing, and stated that, by using the brushes, the cleansing of a wound was no longer in any instance a painful process. The chief object, however, of the plan recommended, was to do away with the employment of sponges and other materials commonly used for cleansing wounds, and which some surgeons believe to be a frequent cause of the passage of infectious material from one patient to another. During nearly two years, of 148 patients operated on, excluding hernia operations, in the wards, only four had died.—*Lancet*, Jan. 25, 1873.

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*Treatment of Chilblains.*—F. Rhien recommends an aqueous solution of iodine and tannin as a remedy for chilblains. He says that the result exceeded his expectations—five applications of the remedy being successful. The application has also been tried by others, with good results when properly applied. The solution is made as follows: About an ounce of tannin is dissolved in half a pint of water; seventy-four grains of iodine are dissolved in an ounce and three-fourths of spirit of wine; the two solutions are then mixed, and enough water is added to make up the whole to two and a half pints. The remedy is applied once daily, the best time being before going to bed. The mixture is gently warmed over a very slow fire; the affected part (*e. g.*, the hand) is dipped in it while still cold, and held there until the liquid, on being stirred, feels uncomfortably hot. The vessel is then removed from the fire, and the hand is dried over it, without gloves. The vessel used must be of earthenware or porcelain, not of metal. Care should be taken not to use too great a quantity of iodine, especially when abrasions are present. According to Rhien, four or five applications are sufficient.—*Brit. Med. Journ.*, Feb. 8, 1873.

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*New Method of Treating Intermittent Fevers.*—Dr. Dédat, of Paris, advocates the use of subcutaneous injections of carbolic acid for the treatment of intermittent fevers. The injections are made under the skin of the chest, abdomen, or internal part of the thighs, with a small syringe. The strength of the solution is one part of the acid to one hundred of water. Four injections are made the first day, three the second, and two the third. The first operation, according to Dr. Dédat, always abates the fever, and often cures it definitively. The other two are merely a matter of precaution.—*Lancet*, Jan. 11, 1873.

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*A New Antiperiodic.*—M. Doran has stated in a note to the Academy of Sciences of Paris (*Comptes Rendus*), that he has never known the *laurus nobilis* to fail in quotidian or tertian intermittents. Cases yielded to it that were fruitlessly treated by quinia. He has no doubt that in quartan ague it would be equally efficient. —*The Doctor*, Dec. 1872.

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*Coffee and Sulphate of Quinia.*—M. Briquet considers the common practice of administering quinia in coffee open to much objection. He alleges that the tannin in the coffee coalesces with the quinia, forming a tasteless and insoluble and almost inert salt—the tannate of quinia, from which the stomach has as much difficulty in extracting quinia as from powdered bark. It is, he thinks, one of the worst preparations of quinia.—*Brit. Med. Journ.*, Feb. 8, 1873.

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*Anodyne Colloid.*—Dr. M. H. Lackersteen gives (*Brit. Med. Journ.*, Dec. 21, 1872) the following formula for a topical anodyne colloid which he has found useful in neuralgia, sciatica, lumbago, all muscular pains, etc. It relieves local pain for the time, and procures a good night's rest. ℞.—Hydride of amyl, ʒj; aconi-

tia, gr. j; veratria, gr. vj; ethereal collodion to ʒij. The amyl, by its rapid volatilization, often produces, almost instantaneously, the desired result; but, should the pain continue, the alkaloids can be brought into activity by applying a piece of moist spongio-piline over the collodion film. The amyl hydride is the only new ingredient; but I think the colloid is a clean and elegant preparation.

—

*Therapeutic Value of Silicate of Soda.*—MM. Papillon and Rabuteau recently communicated to the Academy of Sciences at Paris, a report of their interesting researches on the action of silicate of soda. The therapeutical effects of this salt are especially worthy of notice. They have recently been tested by some of the hospital surgeons here, particularly Dr. Marc Sée and Dr. Dubreuil, and the results have been very remarkable. Silicate of soda is said by them to be highly efficacious in catarrh of the bladder, where the urine tends to undergo ammoniacal fermentation, in venereal runnings, in specific ulcerations, etc. It acts in dissolving and destroying organic corpuscles, the globules of pus, and all the microscopical parasites which produce corruption. It also seems to exert a certain action on the tissues. In their communication to the Academy the authors draw the attention of the profession to various other therapeutical properties of the salt, but they add that as yet they are not able to assert the perfect harmlessness of silicate of soda taken internally.—*Lancet*, Dec. 21, 1872.

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*The Treatment of Prurigo and Pruritus by Carbolic Acid.*—Dr. Rothmund (*Ærztl. Intelligenzblatt*, 39, 1872) states that the internal administration of carbolic acid in pruritus excels every other method. He has tried also the hypodermic injection of it with marked success, there being no local irritation produced as one would expect beforehand. Solutions of pure carbolic acid seem to be more efficacious than those of carbolate of soda.—*The (London) Medical Record*, Jan. 22, 1873.

*Volatile Oil of Celery in Amenorrhœa.*—Dr. Gamberini, in the *Revue de Thérap. Med.-Chir.*, speaks highly of the volatile oil of celery in amenorrhœa, and cites three cases in which the effect of the oil was remarkably good.—*Lancet*, Feb. 1.

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*Treatment of Cholera by Chloral.*—In an article in the *Allgemeine Medic. Central Zeitung*, Dr. Blumenthal states that he and two of his colleagues treated eight cholera patients in the Riga Hospital with hydrate of chloral. With the exception of two, all recovered. In one of the fatal cases, the patient was moribund when the chloral was given; the other death occurred in a pregnant woman aged 35. The most obvious effect of the chloral in the cases that recovered was early arrest of the vomiting and diarrhœa.—*British Med. Journ.*, Jan. 11, 1873.

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*Acid Smell of the Breath in Diabetic Patients.*—M. Duboué, of Pau, has observed a peculiar acid smell of the breath in four patients affected with diabetes. The symptom may be of use in certain cases where the existence of diabetes had not been previously suspected.—*The Lancet*, Dec. 28, 1872, from *Trans. of the Soc. de Chir. of Paris.*

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*Rise of Temperature after Thoracentesis.*—Dr. Laboulbène has just published, in the *Gazette des Hôpitaux*, eight cases of thoracentesis, in all of which the temperature rose two-tenths or five-tenths of a degree after the operation. Dr. Laboulbène remarks that the rise of temperature is very likely due to the more regular and perfect performance of respiration as the lung corresponding to the pleuritic effusion ceases to be compressed.—*Lancet*, Jan. 11, 1873.

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*Impediments to Micturition in Children.*—At a recent meeting of the Medical Union in Vienna, Dr. Englisch described (*Wiener Med. Wochenschrift*, Nov. 23d, 1872) the following conditions as producing impediment to the flow of urine in children, and illustrated his remarks by preparations. 1. In many cases there is mem-

branous occlusion of the external orifice of the urethra, extending generally some way into the canal. 2. The urethra may be obstructed by broad valves, with the free edge lying towards the bladder. They occur rarely in the penile portion of the urethra; more frequently at the caput gallinaginis. Similar valves are met with at the neck of the bladder and in the ureters. The retention of urine produced by them may be so great as to produce thickening of the bladder, and ultimate dilatation of the ureters and renal pelves and disease of the kidneys. 3. The orifice of the urethra or the canal itself may be the seat of stricture, the result of inflammation; or may be pressed on by tumours. 4. Cystic and polypous growths are causes of difficult micturition. The former may be the result of retained secretion (affecting Littre's glands in the female, and the sinus pocularis in the male), or new growths. The former always occur in the middle line, at the junction of the bulbous and spongy portions of the urethra. 5. Dr. Englisch has found polypous growths only at the prostatic portion and the vesical orifice of the urethra. 6. Hyperplasia of the prostate is a very common cause of difficult micturition; it is no doubt congenital. 7. Difficulty of micturition may also be produced by other causes acting externally to the urethra. Thus ascites may give rise to inflammation of the cellular tissue of the pelvis, and to periurethritis.—*Brit. Med. Journ.*, Dec. 28, 1872.

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*Remenstruation by the Breasts at advanced age.*—Dr. Tueffard relates (*Union Méd.*, Nov. 30) the case of a lady, aged 56, in whom menstruation had ceased at the age of 50 without any disturbance of the health ensuing. Four years since she had a superficial ulceration of the os uteri, which soon yielded to treatment. In November, 1871, the breasts became large and firm, with projecting nipples, whence a fluid—at first serous, and then of a bloody colour—was discharged. This discharge continued for about eight days, when it gradually ceased, to reappear again in a month, accompanied with cephalalgia, loss of appetite, and swelling of the breasts. Down to the present time it has continued to reappear every month with almost an exact regularity, the patient being aware of its approach almost as surely as a young woman is of that of her menses. During the intervals the breasts become again flaccid. There is no uterine disease, and in other respects her health is quite good.—*Med. Times and Gaz.*, Dec. 14, 1872.

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*Fatty Liver in Females during Lactation.*—In a recent communication to the Paris Academy of Sciences, M. de Sinetti stated that in the females of all animals the liver constantly presents, during the period of lactation, a characteristic fatty condition. Contrary to what habitually takes place in fatty liver, the adipose substance spreads from the centre to the periphery, instead of from the surface to the centre. These results have been observed in wild and domestic animals, and also in women.—*Lancet*, Jan. 11, 1873.

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*Muscular Anomalies.*—Alex. Macalister has compiled a descriptive Catalogue of Muscular Anomalies in Human Anatomy (*Trans. Royal Irish Acad.*, vol. xxv.), which will prove of great value to all students of this branch of anatomy. He has made a careful search through the extensive literature of the subject, has classified the variations which have been described, and has incorporated with them a number of examples that have come under his own observation.

—

*The Transfusion of Blood.*—The Transfusion Committee recently appointed by the Obstetrical Society of London, has adopted the following programme of its aims and objects. 1. To collect evidence from gentlemen who have had experience in cases of transfusion. 2. To obtain the particulars of all recorded cases (performed on the human subject), with the view of finding out, as far as possible, to what extent the so-called successful cases were due to transfusion. 3. To examine the various kinds of instruments used in both the *mediate* and *immediate* forms of the operation. 4. If considered necessary, to

institute further experiments for the purpose of determining how far transfusion may be relied upon as a means of saving life, and also the best mode of performing the operation. The Committee will be happy to receive communications on this subject, which should be addressed to the Honorary Secretary, Dr. Madge, at the Society's Library, 291 Regent Street, W. In so useful a labour, it is desirable that the Committee should be supported by all who are able to afford information on the subject.—*Brit. Med. Journ.*, Feb. 8, 1873.

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*The Medical Societies of London.*—The following gentlemen have been elected to the office of President of the several Medical Societies of London: The Royal Medical and Chirurgical Society, Dr. C. J. B. Williams; the Pathological Society, Sir William Jenner; the Obstetrical Society, Dr. Edward John Tilt; the Harveian Society, Dr. T. Ballard; the Clinical Society, Prescott G. Hewett; Medical Microscopical Society, Mr. Jabez Hogg.

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*Dictionary of Medicine.*—Messrs. Robin and Littré have submitted to the Academy of Sciences the new edition of their Dictionary of Medicine. It is said to be especially rich in its etymology and definition of medico-scientific terms.

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*Library of M. Daremberg.*—This valuable library, it is said, is to be purchased by the French Government and given to the Academy of Medicine.

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*Relapsing Fever* has appeared again in London, and is on the increase.

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*Cholera* is epidemic in Hungary. 914 cases have been reported, of which 367 were fatal, 386 cured, and 161 under treatment.

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*The Epizootic.*—The horse distemper has appeared in the Isle of Man, and is reported to be spreading through the island.

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Obituary Record.—Died of apoplexy, at Worcester, on the 22d of December, Henry Douglas Carden, Consulting Surgeon to the Worcester Infirmary. Mr. Carden is known to the profession as the introducer of amputation by the "single flap" method (*British Med. Journal*, April 16, 1864); an operation which has found a permanent place in the practice and literature of surgery. He enjoyed the reputation of being a skilful and masterly operator.

—— at Amiens, his native place, Jan. 10, 1873, from the effects of cerebral hemorrhage, M. Dubois (d'Amiens), perpetual Secretary of the Academy of Medicine, the duties of which he has been unable to perform since his attack three years since.

—— at Paris, Jan. 13, 1873, aged 68, from cancer of the upper jaw, M. Huguier, an eminent obstetrician, and formerly surgeon to the Hôpital Beaujon.

—— at London, on February 3, in his 61st year, Isaac Baker Brown, well known as the author of a work "On Surgical Diseases of Women;" his labours in behalf of ovariotomy and for the cure of ruptured perineum, of prolapsus uteri, and of vesico-vaginal fistula, established his repuation as an operative surgeon. In 1855 he was elected President of the Medical Society of London, and in the succeeding year published his work on the Curability of Some Forms of Insanity, Epilepsy, and Hysteria. He believed that epilepsy and other cognate disorders of the nervous system were caused by unnatural irritation of the clitoris, and that excision of that organ would arrest the disease. He removed the clitoris in a number of cases, the results were not satisfactory, and the operation was condemned by the profession. He was so convinced, however, of the correctness of his views and practice, that he published the above-mentioned work, which resulted in his arraignment before the Obstetrical Society of London for unprofessional conduct, and to his expulsion. After the verdict of the Society his practice, which was previously large and lucrative, rapidly diminished. He made several endeavours to retrieve his fortunes, but successive attacks of paralysis shattered his health, and for the last year he has been utterly helpless.

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These are only a few of the points in which the present edition of Mr. Erichsen's work surpasses its predecessors Throughout there is evidence of a laborious care and solicitude in seizing the passing knowledge of the day, which reflects the greatest credit on the author, and much enhances the value of his work. We can only admire the industry which has enabled Mr. Erichsen thus to succeed, amid the distractions of active practice, in producing emphatically THE book of reference and study for British practitioners of surgery.—*London Lancet*, Oct. 26, 1872.

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## LECTURES.

*The Relative Frequency of Disease between the Right and Left Sides of the Heart. Degeneration of the Heart; its Causes and Means of Avoidance.* By CORNELIUS BLACK, M.D. (Continued from p. 38.)

THE effects of imperfect aeration of the blood are traceable in the tissues of the heart. They vary, however, according to the degree of impregnation of the blood with carbonic acid and to the length of time which such blood has circulated through the nutrient vessels of the heart.

Before tracing these effects, it may be observed that those in whom the muscular fibres of the heart have, in consequence of confinement to close, ill-ventilated apartments, undergone the particular degeneration in question, and in whom the blood retains a greater than normal proportion of carbonic acid, are never well. It would be impossible, until somewhat late in the disease, to put the finger upon any one organ and be able to say, Here is the disease. Still, every organ is depressed in its functional manifestation, and the whole body is changed in its sensibilities, its impressions, and its powers. The prevailing indications of disturbed health are—extreme muscular debility, inaptitude for exertion, depression of spirits, frequently an exquisite sensibility

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of the cutaneous nerves, feebleness of the pulse, variable appetite, and weak digestion. The bowels are generally sluggish, and their evacuations darker than natural, from the presence of almost black bile. Such, too, is often the condition of the blood and of the containing vessels, that a slight bruise of the skin produces an ecchymosis of unusual extent, which is exceedingly slow in being absorbed.

All such patients occupy in the daytime rooms from which they exclude every breath of air, provided they have the means of doing so; and where poverty prevents them from fully gratifying their sensations, they nurse themselves accordingly. At night, the one who is able to command the "comforts of life" retires to a feather bed surrounded by curtains closely drawn together, with door and windows closed, gas flaring, and fire burning; the other, whom poverty oppresses, betakes himself to a small, low, dark, ill-ventilated room, where, with his wife and four or five children, huddled together in a couple of beds, he passes the night in an atmosphere rendered poisonous before morning by the accumulation of carbonic acid.

Years pass in this condition of health; middle age is reached; it is passed; œdema of the feet at length sets in; general dropsy follows, from which the passage to the grave is but short. A short time before death occurs—a little before or about the time of the commencement of the œdema of the feet—tricuspid incompetency and jugular pulsation are detected. At length the patient dies; a post-mortem examination is made, and the following condition of heart is found:—

It lies in its pericardium surrounded by serum, apparently somewhat enlarged, the enlargement being due to dilatation of the ventricles, but of the right ventricle chiefly. Its superficial veins are large and distended with black blood; and the general surface of the heart is of a dull, slaty-red colour. This colour pervades the entire thickness of the heart's walls and the endocardium throughout both auricles and ventricles. On being handled, the heart is found to be soft, flabby, and seldom indeed above the average weight. The walls of the right ventricle are larger but thinner than natural; and occasionally the left ventricle is also reduced in thickness. The curtains of the tricuspid valve, on being rubbed between the thumb and finger, are found to have lost their natural feel, and the impression of softness and laxity of tissue is conveyed. They no longer meet so as to close their respective apertures; for, although their edges may be so fitted and approximated as to render their closure apparently complete, yet when the heart is placed as in its natural position, and water is poured, however gently and however small in quantity, into the right auricle, it passes at once into the ventricle beneath. Less frequently the pulmonic valves manifest the same condition of incompetency—always a similar want of firmness. The same distension of auricle and ventricle by dark blood as was observed in the dying trout, is here found; but as in the one so in the other, the auricle is more distended than the ventricle.

If now thin sections from the muscular walls of the heart be examined under the microscope, the following important changes are observed: The minute veins lying on the outer surface of the muscular fibres are distended with dark blood; the muscular fibres themselves are less firmly and less closely knit together, and show a disposition to separate into their ultimate fibrillæ; whilst the cells or disks of which these fibrillæ are composed are, in like manner, less cohesively bound together. Instead of forming apparently flat disks or cells packed face to face in close linear arrangement, it is found that they are increased in their longitudinal diameter, and that they have in consequence assumed somewhat of an oval shape. The effect of this change seems to be to increase the distance between the transverse striæ, and to render the latter much less distinct than in the healthy fibre of the heart. Here and there along the course of a fibre small fissures or rents are observed, through which the sarcous element protrudes, enabling the observer, by the eversion of the edges of such fissures, to discover a containing sheath or sarco-

lemma, as in the voluntary muscular fibre of other organs. In the course of the various fibillæ of which a fibre is composed, one or more of the disks have assumed a round, cell-like form, which in most instances is distended with a dark-looking serosity, but which in other instances contains a clear, bright, highly refracting substance. The former fluid is a portion of the serosity of the blood which has escaped by transudation from the overlying veins and permeated the underlying cell-walls. Its particular color is due to a minute quantity of hæmatine furnished by dissolved blood-corpuscles. The bright, highly refracting contents of other cells are due to the presence of oil.

Not less remarkable are the changes found in the non-striated muscular fibres of which the heart's walls are in part composed. They are flatter and broader than natural, their edges are more irregular, the contents of the tubular sheath are less granular than in health, and they are of the same dark colour as the contents of the altered cells of the striated fibres. Some of their nuclei have undergone more or less conversion into fat, and minute globules of oil are seen here and there along the course of the fibres. Fat, however, is not a nesessary element of this form of tissue-degeneration, because many instances occur in which it does not exist.

The degeneration in question is not only characterized by the microscopic and other appearances already stated, but by the presence of a superabundance of serosity, which saturates, as it were, every individual fibre, rendering the whole mass of the muscular walls of the heart soft and diffluent to the touch.

In the musculi pectinati similar appearances are observed. The epithelium of the endocardium is extremely thin and badly developed, and in some places detached from its basement membrane, which presents the same dull, slaty-red colour as the muscular structure of the heart. The basement membrane is likewise soft and pulpy, and the vascular layer consists of vessels so dilated and distended with dark blood that the interspaces are considerably reduced in size.

The connective tissue is generally free from any inflammatory exudation, but the fibres of which it consists lie bathed in the same kind of serosity which distends some of the altered cells of the striated fibres.

Now, this pathological condition of the heart, which is the result of deficient aeration of the blood extending over a long period, is distinct from every other known morbid process which affects the heart. It has no connection with inflammation, and it is distinct from fatty degeneration, with which, however, it may, as we have seen, be associated. I therefore claim for it a distinct place in the nosology of diseases of the heart. It is, perhaps, difficult to adopt a term which shall sufficiently express the true nature of the disease; but as the changes produced in the heart are manifestly due to the action of a hyper-carbonized condition of the blood, the term *carbonized heart* may serve the purpose of distinguishing it from other affections of this organ.

From the condition in which the striated fibres are found, it is easy to explain why, during life, the action of the heart is so feeble and the pulse so small—why the patient always complains of feeling an amount of prostration which cannot be explained by general appearances—why there is such breathlessness on the least exertion—why death often occurs suddenly.

In the healthy heart the flattened disks forming the ultimate structure of the muscular fibrillæ are in two opposite conditions according as the fibrillæ are in a state of relaxation or contraction. When relaxed, the longitudinal diameter may equal or exceed the transverse diameter, and the muscular striæ are in consequence carried farther apart from each other; but when the fibrillæ are in the opposite state of contraction, the transverse diameter exceeds the longitudinal, and the muscular striæ are brought into closer approximation. In the diseased condition of the heart in question, the longitudinal diameter of the individual disks or cells of the fibrillæ is greater than natural. The tendency of the disease is, therefore, to cause the longitudinal to prevail over the transverse diameter, and,

as the disease progresses towards this end, to weaken the heart's power of contraction; because power is represented by the degree in which the transverse diameter of the cells of the fibrillæ in action exceeds that of the longitudinal diameter.

It is manifest that, as the disease progresses, the cells of the fibrillæ lose by degrees their power of contracting, and that permanent relaxation is the ultimate condition in which they end. When that condition has been reached by a sufficient number of these cells to render the heart unable to force the blood through the extreme vessels, the patient may die from mere failure of the heart's power. Death in such a case has been gradually approaching for some time; but its advent is sudden at last. Upon the increasing debility which has now, perhaps, for weeks been patent alike to patient and to friends, there comes a sudden excitement—an unexpected stimulus to exertion, which causes the patient to put forth an unwonted power; and, in doing so, the heart is overwhelmed by the labour thus suddenly thrown upon it, under which it as suddenly falters—fails—dies!

In other instances sudden death occurs without any previous aggravation of the general condition of the patient. This occurrence is readily explained by the particular condition of the fibrillæ of the heart, as already stated. It has been shown that frequently some of the altered cells of these fibrillæ are distended by a dark serosity, others by oil; and that the sarcolemma in which they are inclosed is often marked by small fissures or rents. Now, if it happens—which is not unfrequently the case—that at any point of the heart this condition of the fibrillæ exists throughout the whole thickness or the greater part of the thickness of its walls, the natural efforts of the heart are sufficient to cause rupture at this point, extravasation of blood into the pericardium, and death. More frequently, however, it happens that, when death from this cause occurs suddenly, it takes place during the performance of some act of physical exertion, which, by throwing a sudden increase of labour upon the heart, excites it to unwonted efforts of contraction, under which the diseased fibrillæ give way.

Another mode in which death occurs in this disease is owing partly to the direct effects of the enfeebled heart, upon the circulation, and partly to the secondary consequences of tricuspid or pulmonic regurgitation, or to both of these lesions combined. The tricuspid incompetency is a frequent, the pulmonic incompetency a less frequent, lesion in this disease. The former produces general dropsy; the latter a particular condition of the breathing, which demands a more extended observation.

When the pulmonic valves are unable to close their aperture, a portion of the blood projected by the right ventricle into the pulmonary artery falls back into the ventricle, and thus diminishes the quantity which would otherwise reach the lungs. This occurring at every contraction of the right ventricle, a period is soon reached when the vessels of the lungs are very inadequately filled with blood. The requirements of aeration increasing with its defective accomplishment, the demand for more air is immediately felt throughout the whole system, but especially in the lungs. To meet the urgent necessity which deepens every moment, the supplementary muscles of respiration are called into play, violent and quickened efforts are made to expand the chest, and the breathing becomes in consequence distressingly laboured and panting. If this condition continues, a diminished supply of blood is quickly felt in the left ventricle, a correspondingly diminished quantity is projected into the aorta, the vessels of the brain being thereby only partially distended, the energy of the brain itself is not maintained, an indescribable feeling of faintness takes place, the countenance blanches, and life is grievously threatened. The recumbent posture at once assumed, a stimulus administered to rouse the energy of the heart, a counter-irritant applied to the precordia, and an abundance of fresh air, are the means to recover a patient from this threatening condition. When, however, this state of regurgitation has been reached, there is no hope of permanently allaying these paroxysmal

attacks, and the breathing is ever afterwards liable at any moment to a recurrence of these painfully panting manifestations. But the regurgitation from the pulmonary artery into the right ventricle produces another injurious effect by causing a too frequent effort of contraction on the part of the heart. It will be remembered that, in detailing the result of my observations on the circulation in the newly-hatched trout, I stated that no sooner did the blood touch the lining membrane of the auricle and ventricle than they quickly, firmly, and resolutely contracted. In like manner with respect to the human heart, no sooner does the blood in the case now under consideration fall back from the pulmonary artery into the right ventricle than the latter, responding to the stimulus thus applied to it, contracts, and the repetition of this effort, occurring more frequently than it is wont in the natural order of the heart's movements, quickly induces exhaustion in the muscular fibres of a heart already diseased, and thereby favours the occurrence of dilatation. To dilatation would be added hypertrophy if the nutrition of the heart were as active as it is in other diseases of that organ; but as the condition of the blood is opposed even to the ordinary nutrition of the heart's structures, simple dilatation of the right ventricle is the most common form of enlargement which is found.

Where the tricuspid valve is incompetent, dilatation of the right ventricle is more rapid in its occurrence than in pulmonic incompetency; but where the two incompetencies coexist, as is sometimes the case, the ventricular dilatation is both more rapidly and more extensively induced than where one or other valve alone is affected.

Practically speaking, our knowledge of diseased action is of no use unless we can recognize it during life. To simply discover its effects after death is of no avail to the living. The question therefore arises—Does this particular disease of the heart give any indications during life by which it can be recognized? Like every other disease, it has its particular and characteristic symptoms. Some of these refer to the heart itself, others to the general system.

Those which more particularly refer to the heart, show that the action of this organ is very feeble, that its sounds are but faintly heard in their accustomed areas, and that the space over which its impulse is felt is less than ordinary. It is sometimes difficult to determine the exact point at which the apex strikes the chest-walls; and when found, the apex-beat is felt as a feeble tap which seems to just touch the ribs and is gone again. When there is tricuspid regurgitation, it is not always productive of a morbid sound either over the lower part of the sternum or immediately to the left of this bone over the body of the right ventricle. The regurgitation more particularly manifests itself by jugular pulsation, which is best seen when the respiration is suspended, and when the external jugular vein is compressed upon the posterior edge of the sterno-mastoid muscle. If the right ventricle is dilated, a feeble impulse or a mere flutter is felt in the epigastrium, which is more distinct at the extreme of expiration than at any other stage of the respiratory movement. To the evidence afforded, by jugular pulsation, of tricuspid incompetency there is soon added, if it does not already exist, that of general dropsy. When the pulmonic valves are incompetent, extreme breathlessness is felt on the slightest exertion, and paroxysms of panting breathing are, independently of exertion, apt to arise, during which the countenance of the patient becomes distressingly pale and betrays an expression of the greatest anxiety.

Of the general symptoms, the most prominent one is, as it has already been shown, a feeling of the most complete muscular debility. The sense of prostration is indescribably great. Where there is no valvular lesion, the breathing is nevertheless rendered short and hurried on the least exertion. The patient, after making the least effort, sinks into a chair, complaining of faintness, and gaspingly exclaims that "it is too much" for him. Hence the indisposition of the patient to move about.

In almost every instance the temperature of the skin is below the natural standard; nevertheless, there is frequently, especially when the patient is a female, a hyper-sensibility of the cutaneous nerves, which is resolved into acute pain upon the slightest pressure, and which renders the patient so sensible of the merest change of temperature, that the admission of fresh cool air into the apartment is studiously avoided. A gentle tap upon the skin, the mere grasp of a part, or even the pressure of a finger upon any part of the surface, is followed by extravasation of blood, which is exceedingly slow in being absorbed.

The general hue of the countenance is a dirty pallor, and a faint, slaty-blue deepens in the early stages the natural colour of the mucous surfaces, which gives place to a deeper blue of the lips and of other parts when valvular lesion is afterwards superadded.

The appetite is variable—never large—always, perhaps, below the healthy standard. Still, food is taken every day in moderate quantity. Uneasiness of the stomach generally follows the ingestion of food, and flatulent distension often adds to the miseries of the patient.

The bowels are generally more or less torpid, and the evacuations darker than natural, thus showing the attempt on the part of the liver to depurate the blood by removing an excess of carbon in its secretion.

Like the bodily functions, the mental manifestations are low. Depression of spirits, gloomy anticipations, and a nervous anxiety about particular sensations, especially the sensation of cold, are the leading features of the mind.—*Lancet*, Sept. 28, 1872.

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Clinical Lecture on Renal Disease in Calculous Patients, and its Influence on the Choice of Operation.* By Sir Henry Thompson, M.B., Surgeon-Extraordinary to His Majesty the King of the Belgians; Surgeon to University College Hospital.

[Considerable interest attaches, in connection with the death of Napoleon III., to the following lecture, which includes a discussion of all the points bearing upon that now celebrated case.]

The patient, a naval pensioner, aged 60, thin and careworn, had suffered from symptoms of stone for more than three years. In the course of 1872, he had been admitted into a metropolitan hospital, when the stone was crushed several times. After this, the patient continued pretty comfortable for about three months; he then rapidly relapsed, and when he came under Sir Henry Thompson's care, the old man was in a most miserable condition. He could not hold his urine more than half an hour, even at night, and, as he could only pass it when in the erect position, he was obliged to leave his bed every time, and was greatly reduced by pain and want of sleep. His urine was alkaline, of low sp. gr., contained a large amount of albumen, and an unmistakable granular cast found under the microscope at the first examination. On sounding him, fragments of phosphatic stone were detected. It was evident that the patient had advanced disease of the kidneys, and that his ultimate fate was settled; still, his principal sufferings were due to the presence of the calculous matter in the bladder, and these could be removed or greatly relieved by lithotrity.

He was accordingly admitted into the hospital on January 21st; the 24th, Sir Henry removed some *débris*, and repeated the process on the 28th without any unfavourable symptoms; on the contrary, the patient during this time improved in strength, could move about better, and was able to hold his urine for an hour or more at a time. All but a few fragments had in fact been removed when, on Februrary 1st—a cold day—the patient slipped out of the ward and stood for some time in the yard of the hospital smoking. Next day, he had a severe rigour, followed by headache, drowsiness, partial suppression of urine, etc., and, although at first he rallied somewhat under treatment, he never recovered from the effects of his unfortunate indiscretion, and died on February 19th of uræmia.

*Post-mortem Examination.*—The external surface of the kidneys was granular; the capsules were opaque and adherent: on section, the cortical layer was thin, mottled with patches of yellow degeneration, and studded here and there with small abscesses; the pyramids were congested. The pelves of the kidneys and the ureters were dilated, and contained puriform matter. The muscular coat of the bladder was hypertrophied; the mucous membrane was much congested, dark, thickened, opaque, and ulcerated in places; the so-called "middle lobe" of the prostate was much enlarged, forming a regular bar across the neck of the bladder; in the deep hollow behind this were a few small and soft fragments of stone, weighing in all twelve grains.

In commenting on this case, Sir Henry Thompson said: The question we have to consider to-day, gentlemen, is this, If stone in the bladder be complicated by the presence of chronic renal disease, what should be done? When are we justified in operating? and which operation should we choose? "Chronic renal disease" is a wide term; and, in order to answer the question better, I will consider the chief forms of kidney-disease separately.

We may at once dispose of malignant disease; if this be so advanced that a satisfactory diagnosis is possible, any operation is clearly useless. Chronic Bright's disease, again, is a loose term, and includes several varieties; the two that chiefly concern us now are the large white smooth kidney, and the granular contracted kidney: the so-called amyloid disease is rare. There is no difficulty in the diagnosis of Bright's disease, even when complicated by the presence of stone; the low specific gravity of the urine, the presence of casts and of an amount of albumen out of proportion to the amount of pus present decide the nature of the case at once. Next, there is what may be called the calculous kindney. You will often meet with men who are frequently, or almost continuously, passing crystals of uric acid or small calculi. This never goes on for any length of time without damage to the kidney; on microscopic examination, you will always find blood in the urine. They are often stout red-faced, healthy-looking rustics; but if such a man come to you with a stone in his bladder, and tells you that he has been accustomed to pass gravel for years, beware of him; in spite of his apparent good health, he will be unusually liable to severe rigors and urinary fever.

Next, saccharine diabetes is occasionally associated with stone. I have met with two such cases, and never had any more troublesome: there was in both very great irritability of the bladder and of the system generally; and if you should meet with the same complication, the case will probably require all the care and patience you can muster.

Lastly, there is that dilated condition of the kidney and the ureters which is due to long-standing obstruction in the passages. This has been sometimes called "surgical kidney," a most inappropriate and unphilosophical term, and one which I never use. So far from being really a "surgical" kidney, it is one which denotes the want of surgical treatment; one which never would have existed had surgical aid been afforded at the outset of the malady. This condition is most frequently met with in cases of old stricture, also in cases of enlarged prostate, large calculus, long-continued atony of the bladder, etc. Owing, then, to the presence of some obstruction to the escape of urine from the bladder, that organ becomes dilated and hypertrophied, the pressure tells backwards on the ureters, these and the pelves of the kidneys become dilated, the secreting substance itself is compressed against the capsule, and, finally, the whole organ may be distended into a sort of cyst. I have seen the ureters as large as the small intestine, and contain, with the pelves of the kidneys, thirty fluidounces of water. A calculus by itself never produces this effect unless it be large, and not necessarily even then; it depends on the amount of obstruction. And now comes an important fact, viz., that all this may occur without any distinct symptoms; you may suspect that this state of things is present, but you cannot make absolutely sure. The patient probably has

some cystitis, and consequently pus in his urine, but there is no more albumen present than the pus would account for; there are no casts; the urine may be of fair specific gravity, and there will even be no deficiency of urea; if there be, the patient will at once show symptoms. The fact is, that we are liberally provided with secreting and excreting organs. A man may live very comfortably, even though a considerable proportion of both lungs be blocked up with tubercle; two half lungs are sufficient under ordinary circumstances; but if he get a little bronchitis —an amount which a healthy man would scarcely feel—it carries him off; he has just enough breathing space to sustain life, but no margin to spare. Just so a man may live with two half kidneys; he gets along quite well under ordinary circumstances; there is just enough of the organs left to meet the wants of the system, but any small derangement upsets the balance, and serious symptoms appear at once.

A high authority abroad has stated that this state of the kidneys can be diagnosed by means of palpation, but I cannot confirm his assertion. It would be exceedingly difficult to detect with certainty a soft, movable, and collapsible tube like the ureter even in a thin person; but generally these patients are past middle life, and stout also from confinement; the parts are not sensitive, unless suppuration or a renal calculus be present. You may often be able to make a shrewd guess; but even a strong suspicion is not a sufficient ground for refusing to relieve a suffering patient.

In the next place, to what extent does the presence of renal disease affect the prognosis of lithotrity? Omitting slight cases, I have operated on three patients who were suffering from *advanced* chronic Bright's disease. The first was some years ago. A very pale, weak, and puffy-looking man, with a large phosphatic stone, came to me to be operated on, but I refused; he, however, begged so hard that I would do something for him, and was in so much pain and distress, that at last I took him in. Even then I kept him three weeks under observation before I did anything, which is not my usual custom. I then crushed the stone very carefully in eight sittings, allowing a good interval between them. The man was in the hospital three months—three times as long as most of my patients—but he went out freed from his trouble, and died of the kidney-disease nine months afterwards without any recurrence of the calculus.

Some time afterwards, I operated on a second and similar case. He had some rigours, but went out at the end of ten weeks cured of his stone; he came to show himself three months afterwards, when he had still a large amount of albumen in his urine, but no recurrence of the stone. Emboldened, perhaps, by success, I attempted a third and worse case shortly afterwards. This patient went on well for a time, but after the fifth sitting uræmic symptoms supervened, and he died.

I cannot tell how many cases of mechanical dilatation of the kidney I may have operated on with success; for, as I said, I know no means of ascertaining with certainty during life the existence of the disease; but I have little doubt that there has been more or less distension of the ureters, etc., in a considerable number of the more severe cases. I may instance particularly three cases of stone complicated by very tight and old-standing stricture. My plan under such circumstances is to tie in catheters for a week, or until I can introduce a small lithotrite; after each crushing I replace the catheters, and continue them until the stone is removed. I have not the smallest doubt, judging from the history and state of these patients, that all had some, perhaps a considerable, amount of disease; yet in each case the result was successful.

Surgeons have said that, if a patient with stone in the bladder have also chronic disease of the kidneys, the best plan is to cut him; to have one operation and have done with it, and not to go on teasing the man with instruments for several weeks. I can only say that lithotomy would certainly have killed any one of the three pale, feeble, bloodless patients

I first mentioned; indeed no one of the six could have been cut—no surgeon would have thought of it. It is just fifty years since lithotrity was first introduced, and up to thirty years ago, or less, this dictum was true, but it is not so now. The statistics of lithotomy were never better than they were fifty years ago; indeed they are now scarcely as good, for since then many of the most favourable cases have been treated by crushing. The statistics of lithotrity, on the other hand, have improved, and are improving every year. Lithotomy, then, has stood still; lithotrity has been greatly improved, and the axiom is consequently now reversed. There is no doubt with our present experience that, if only the stone is sufficiently friable, lithotrity, *if skilfully performed*, is the best operation in such cases: the shock, loss of blood, etc., of lithotomy make considerable demands on the strength of the patient. The lithotrity must, I repeat, be very carefully done; of the two operations, that of crushing is certainly the one in which previous practice on the part of the operator makes the greater difference in the chance of curing the patient. Therefore, I say to you, inasmuch as you may be well able to do a good bold operation of lithotomy at the outset of your career if you have surgical talent at all, do so with any doubtful case, or if the stone be at all large, until you have had a little experience with two or three cases of small stones by lithotrity. Whatever you do by that means, let your early attempts be always made on small calculi only.

In conclusion, I may repeat the advice which I am constantly giving you. Always find the stone, if possible, when small; the symptoms produced by a stone, say of the size of a nut, are clear enough. There is no question, then, about the advisability of cutting or crushing, or about the presence or absence of kidney-disease; crush the stone at once, and the cure of the patient is almost certain.—*British Med. Journ.*, March 8, 1873.

[A *verbatim* report of the above lecture, which has had the advantage of Sir Henry Thompson's personal revision, will be found in the *Lancet* for March 8.]

## HOSPITAL NOTES AND GLEANINGS.

*Three Operations for Removal of the Tongue by the Galvanic Écraseur.*—At University College Hospital, Mr. Erichsen has, during the last few months, three times removed the tongue for epithelioma—all successfully as to the immediate result of the operation, but, unfortunately, followed in the first two cases by recurrence in the glands. The three operations were performed in three different ways. In the first the jaw was divided, as, from the situation of the growth, very free access to the base of the tongue was required. In the second the operation was performed through the mouth; and in the third the mouth was laid open through the cheek, as it was intended to remove only half the tongue, the disease being completely limited to one side. The instrument used for the actual removal was, in all cases, the galvanic écraseur, an instrument which, for such operations, is invaluable. In each case the time occupied in cutting through the tongue was barely two minutes, and not a drop of blood was lost.—*Irish Hosp. Gaz.*, March 1, 1873.

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*Attempted Reduction of Dislocation of Shoulder-joint; Rupture of Axillary Artery; Death.*—The patient was admitted into the Royal Infirmary, Edinburgh, under the care of Mr. Lister, on account of an unreduced dislocation of the shoulder-joint of seven weeks' standing, but said by the patient himself to have been of only five weeks' duration. Professor Lister, by manipulation and subsequently by the pulleys, attempted to reduce the dislocation, no undue force being exerted by either method. During the attempt a sharp crack was heard, and subsequently a swelling, which ultimately reached the size of an adult head, took place on the dorsal and posterior part of the scapula; the occurrence being due to the rupture of the axillary artery, and subsequent effusion of blood into the surrounding textures. Without hesitation Professor Lister cut down on the spot, and proceeded to search for the ruptured vessel, opening by his incision into a sacculated structure

into which the blood had been effused, and from the bottom of which the blood appeared to flow. Careful search for the source of the hemorrhage was, after a considerable period of time, rewarded, by finding that the bleeding point was situated on the posterior aspect of the artery itself—a situation which, the Professor remarked, was rather unusual, and not likely to be easily got at or seen. The vessel was accordingly ligatured above and below the bleeding point, antiseptic measures being taken during and after the operation to prevent the occurrence of putrefaction. The patient rallied immediately after the operation, but sank and died in about three hours subsequently. Professor Lister remarked on the importance of the occurrence from a practical point of view, at the same time remarking on the obvious duty of at once cutting down and securing the bleeding vessel. A dissection of the parts showed several features of interest. The humerus had attached to its shaft a little spiculum of bone, which was evidently the immediate cause of the perforation of the artery, which itself was highly atheromatous, and so rendered the more friable. The head of the bone had, during the comparatively short period of seven weeks, formed for itself a false glenoid cavity, in which it had been reposing; the existence of this structure forming an additional element in the difficulty of successfully or readily reducing the dislocation. Short as the period had been, it was instructive (said Professor Lister) to note that this cavity was not only of cartilaginous texture, but even exhibited traces of osseous development also. Professor Lister, in conclusion, regretted that he had not instructed his house-surgeon to send for him at once on the intervention of the serious later symptoms, as the case would have presented the most favourable aspects for the performance of the operation of transfusion of blood from the veins of a person willing to furnish the requisite supply.—*Med. Times and Gaz.*, Feb. 1, 1873.

[Mr. Callender (*St. Bartholomew's Hospital Reports*, vol. ii. p. 96) has collected the reports of thirty-one cases of this rare accident.]

# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*Aphonia during Pregnancy.* By Chas. E. Reiler, M.D., of Dixfield, Me.—Mrs. B., aged 34, primipara, nervous, was delivered Nov. 9, 1871. The child nursed until the last of May, 1872, when the mother's milk suddenly dried up. In a few days she became troubled with morning nausea and vomiting; menses had not appeared since her pregnancy. About the first of June, 1872, I was called to see her, and concluded that she was again pregnant. About ten days after this I was again sent for, and found that she could not speak, except in a whisper, and that very imperfectly. I told her that I thought that she would talk again after delivery. On the morning of February 11, 1873, I was called to see her in labour. On arriving at the house, her nurse told me that she had not spoken aloud until about half an hour before my arrival; the waters broke, and she spoke a few loud words. Pains continued at intervals through the day; got several hours of sleep during the night.

*Feb. 12th.* Pains continued all day, becoming more regular and stronger towards evening. At half past eight in the evening, the os being dilatable, though not dilated more than an inch, and the labor so protracted, I concluded to rupture the membrane, when an unusually large quantity of liquor amnii passed, and at that moment the voice returned perfectly natural, and as strong as ever; at half past nine I delivered her of a male child, weighing $10\frac{3}{4}$ pounds. The case is now doing very well.

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*Post-mortem Delivery.*—Dr. D. Rogers of Topeka, Kas., reports to us the case of Mrs. E. J., aged 19, who had been married ten months and who, when far gone in pregnancy, was taken sick with typhoid fever, and on the tenth day died without any sign of labour being detected. Some time after death she was delivered of a dead infant of medium size.

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*Skunk Bites.*—Dr. W. W. Fox, of Kansas, relates briefly (*Medical Herald*, March 1,

1873), five cases in which persons bitten by skunks died with symptoms resembling hydrophobia.

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*American Medical Association.* — The Twenty-fourth Annual Session will be held in St. Louis, Mo., May 6, 1873, at 11 A. M.

*Officers of Sections.—Chemistry and Materia Medica:* Drs. R. E. Rogers, Philadelphia, Pa., Chairman; Ephraim Cutter, Boston, Mass., Secretary.

*Practice of Medicine and Obstetrics:* Drs. D. A. O'Donnell, Baltimore, Md., Chairman; Benjamin F. Dawson, New York, N. Y., Secretary.

*Surgery and Anatomy:* Drs. Edward Warren, Baltimore, Md., Chairman; W. F. Peck, Davenport, Iowa, Secretary.

*Meteorology and Epidemics:* Drs. George Sutton, Aurora, Ind., Chairman; Elisha Harris, New York, N. Y., Secretary.

*Medical Jurisprudence, Hygiene, and Physiology:* Drs. S. C. Busey, Washington, D. C., Chairman; A. B. Arnold, Baltimore, Md., Secretary.

*Psychology:* Drs. Isaac Ray, Philadelphia, Pa., Chairman; John Curwen, Harrisburg, Pa., Secretary.

Secretaries of medical organizations are requested to forward lists of their delegates to the Secretary, Dr. Wm. B. Atkinson, 1400 Pine Street, Philadelphia.

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*Medical Literature.*—Dr. Austin Flint, of New York, Chairman of the Committee on Medical Literature of the American Medical Association, wishes to obtain as complete a list as possible of American medical works, of new editions, and of republications of foreign works, published between May, 1872, and May, 1873, to be embraced in his report to be made at the next meeting of the American Medical Association. He asks to this end the aid of editors of journals and publishers of medical works throughout the United States.

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*University of Pennsylvania. Practical Microscopy.* — Arrangements have been made by which all the members of the spring and fall classes at the University of Pennsylvania may have the opportunity of actual practice with the microscope, under the direction of the instructor in this department, James Tyson, M.D., on the payment of a small fee for the use of instruments.

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*Stevens Triennial Prize.*—This Prize for 1873 has been awarded to an Essay on

*The Sphygmograph; its Physical and Pathological Indications.* By Edgar Holden, M.D., of Newark, New Jersey.

The questions proposed for the next prize (1876), are as follows:—

I. *The History of Epidemics in the United States from* 1860 *to* 1870; statements as to localities, dates, extent of prevalence, and mortality, to be authenticated by appropriate references. The question of *treatment* is not to form a part of the above subject.

II. *The Use of the Spectroscope, in its Application to Scientific and Practical Medicine.*

The competing essays on either of the above subjects must be sent in to the President of the College of Physicians and Surgeons, New York, on or before the first day of January, 1876. Each essay must be designated by a device or motto, and must be accompanied by a sealed envelope, bearing the same device or motto, and containing the name and address of the author. The envelope belonging to the successful essay will be opened, and the name of the author announced at the Annual Commencement of the College, in March, 1876.

This prize, which will amount to two hundred dollars, is open for universal competition.

By order of the Prize Committee.

J. C. DALTON, M.D.

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*Philadelphia College of Pharmacy.*—At the fifty-second commencement of this flourishing institution, held on the 18th March, the degree of graduate of pharmacy was conferred on 94 candidates.

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*Dr. T. Gaillard Thomas's Work on Diseases of Women.*—We are pleased to learn that this excellent work has been translated into German and published in Berlin.

*Medical Department of the University of South Carolina.*—Dr. R. W. Gibbes has been elected Prof. of Anatomy and Surgery in this Institution, and not in the Medical College of the State of South Carolina, as stated in the February number of this Journal.

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*Hartford Retreat for the Insane.*—Dr. John S. Butler has resigned the superintendency of this institution—a position which he has held for nearly thirty years, and retired to private practice in Hartford. Dr. James H. Denney, for some years assistant physician at the Retreat, has been promoted to the position rendered vacant by Dr. Butler's resignation.

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Obituary Record.—It is with profound grief that we record the death of our nearly life-long friend, Dr. Hugh L. Hodge, Emeritus Professor of Midwifery and of the Diseases of Women and Children in the University of Pennsylvania, which sad event occurred on the 26th of February, after only a few hours' illness, in the 77th year of his age.

Dr. Hodge was well known for the singular purity of his character; his conscientious performance of every duty; the untiring zeal with which he cultivated our science; and the numerous substantial contributions he made to it, which secured to him fame, both at home and abroad. An ardent student, he industriously sought after truth, and fearlessly and earnestly maintained his convictions, but without intolerance, conceding to others, who had arrived at different conclusions, the credit, which he claimed for himself, of perfect sincerity. After a friendship contracted in early boyhood, and continued uninterruptedly for more than sixty years, we can aver our inability to remember a word spoken or an act performed by him which could have been a source of the slightest regret to himself or his warmest friends.

His talents, conscientiousness, genialty, benevolence, amiability, integrity, and unselfishness, attracted to him numerous friends, who must feel that in his death they have sustained a loss which cannot be repaired.

At a special meeting of the College of Physicians of Philadelphia, held Feb. 28, 1873, the following preamble and resolutions, offered by Dr. Alfred Stillé, were unanimously adopted:—

*Whereas*, we have heard with profound regret that our venerable colleague, Dr. Hugh L. Hodge, has died, after a very short illness, while he was still in the full possession of mental vigour, and actively engaged in professional duties; and

*Whereas*, it is due to his memory, and is a solace to our own regret, to place upon record our estimation of his character and services; therefore,

*Resolved*, That by the death of Dr. Hodge the medical profession has lost one of its brightest ornaments and most valable members; a teacher whose learning, eloquence, and wisdom rendered him one of the most eminent and useful professors of the medical school he so long adorned, and of the professional literature to which he contributed the results of his matured experience and reflection; a practitioner sagacious, skilful, and wise, who to the latest day of his life devoted his powers, with rare success, to the alleviation of suffering and the preservation of life, and secured the affectionate veneration of all whom he served; a man who, from the beginning to the end of his career, was not only pure and without reproach, but in every relation distinguished by singular conscientiousness and an earnest piety, and by a dignity of demeanor and consistency of conduct which made his name synonymous with truth and virtue.

*Resolved*, That Dr. H. Lenox Hodge be requested to prepare for the College a memoir of his late father, and that the College will pay the last honours to their distinguished Fellow by attending his funeral in a body.

At a meeting of the Medical Faculty of the University of Pennsylvania, held Feb. 28, 1873, the announcement having been made of the death of Dr. Hugh L. Hodge, Emeritus Professor of Obstetrics in the University, it was

*Resolved*, That the Faculty have heard with sincere sorrow of the death of one who stood in the relation either of preceptor or of colleague to all the members of their

body, and that it is due to his memory to express their high appreciation of his character as a man, and of his distinction as a Professor.

That the pure and elevated principles of Dr. Hodge were illustrated in a life devoted to the service of his fellow-men, and to the promotion of all efforts to benefit and ennoble humanity, while his disinterested, gentle, and humane prosecution of his profession placed him as an example before his brethren, and endeared him to the community in which he dwelt, as well as to those who sought his counsel from abroad.

That his efficient services as a teacher of his art placed him in the front rank of the eminent men who have shed lustre on the Medical Department of the University of Pennsylvania.

That by his lectures and publications he has contributed to the advancement and improvement of his special branch of medicine, and aided in the dissemination of sound doctrine in medical science; and, although for many years retired from the more arduous duties of his profession, his influence has been deeply felt, and cordially acknowledged.

That the Faculty, gratefully remembering the many manifestations of his personal kindness and interest, sincerely condole with the family of Dr. Hodge in their bereavement, and feel that the only consolation for the loss sustained by them is to be found in the assurance of his eternal gain.

The following resolutions were adopted by the PHILADELPHIA COUNTY MEDICAL SOCIETY, February 26, 1873:—

*Whereas*, it has pleased Divine Providence to remove to a happier sphere one of the most honoured members of our Society, who during a long and useful life has ever been noted for the purity and benevolence of his character, not only as a physician, but also as a citizen of Philadelphia: Therefore,

*Resolved*, That the Philadelphia County Medical Society have recently learned, with deep regret, of the sudden and unexpected death of Dr. HUGH L. HODGE, Emeritus Professor of Obstetrics in the University of Pennsylvania, and one of the oldest members of this Society.

*Resolved*, That by the death of Dr. HODGE, this Society has lost a highly esteemed member, whose skill and erudition had gained him a world-wide reputation as an accoucheur, and made him an authority in difficult cases that greatly relieved the anxious hours of his juniors, who were often led, by his courtesy and high professional honour, to avail themselves of his valuable assistance.

*Resolved*, That the members of this Society, most of whom have been his pupils, recall with pride and pleasure the sound and practical precepts inculcated in his teaching.

*Resolved*, That Dr. Wm. Goodell be requested to prepare a biographical memoir of our late member, to be read before this Society.

*Resolved*, That the Philadelphia County Medical Society respectfully tender to his family their sympathy in its affliction.

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## FOREIGN INTELLIGENCE.

*Deaths from Chloroform.*—The *Medical Press and Circular* states "that we have reason to know that a fatal case occurred in private practice during the last twelve months, where, though every precaution was taken, and a skilled chloroformist was intrusted with the administration, death ensued from the first few inhalations, and before a half drachm of chloroform had been used."

On the 14th of Feb. a patient died under the influence of chloroform in Sir Patrick Dun's Hospital, Dublin, while undergoing amputation.—*Lancet*, Feb. 22, 1873.

In the *British Medical Journal* for February 22, 1873, Mr. Richard of the Bristol Royal Infirmary reports the death of a labourer aged 51, from the inhalation of chloroform given to produce anæsthesia during the dressing of a fractured leg. And Mr. Wyman, from a similar cause, that of a woman aged 45 who was about to undergo an operation at the West London Hospital, for the removal of a fatty tumour from the back.

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*Affections of the Skin accompanying Pregnancy.*—Prof. HEBRA has published in the *Wien. Medicinische Wochenschrift*, some

very interesting observations on the various forms of skin disease that are met with in women when pregnant, or during lying-in, or who suffer from disease of the uterus, and which disappear when the physiological or pathological cause which produces them ceases to act; and chief among this class are acne disseminata et rosacea, which are met with in women of otherwise faultless complexion as soon as they become pregnant. In some cases this only goes as far as redness of the nose, in others, to the formation of painful pustules. In some cases conception is quickly followed by eczema. Hebra cites the case of a lady who first was made aware of having conceived by the appearance of a vesicular eruption, accompanied by itching on her hands. In other cases we meet with simple pruritus, or some form of erythema, or urticaria, or even pemphigus. All these different eruptions disappear, however, when the uterus rids itself of its contents. Hebra had one lady under his care, who, during three successive pregnancies, suffered from pemphigus, which twice disappeared on the birth of the child, but became chronic the third time. Under his advice, she spent a considerable time at Vöslau, where she made use of the baths with success. Her husband, however, unable to bear the long separation, surprised her one day by a visit. During the following month, even before she had time to notice any cessation of the menses, she became aware of having again conceived, by being attacked afresh by pemphigus, this time more violent than before, and accompanied by sleeplessness, loss of appetite, and wasting. The pemphigus again disappeared after the birth of a child, to return twice, however, in after years, under the same physiological condition.

Hebra draws attention to the frequent occurrence of chloasma uterinum (the pityriasis versicolor of other writers) connected with changes in the structure and position of the uterus; of chronic urticaria in cases of fibrous or other growths, in the same organ; of acne rosacea in blenorrhœa and ulceration or excoriation of the os uteri; of eczema, seborrhœa, defluvium capillorum in young women suffering from chlorosis (with frequent and profuse menstruation); or in women while they are lying-in, or after they have weaned; while as long as they suckle they are quite well. These facts are valuable as giving us hints as to the right diagnosis, as well as important as regards the treatment, such diseases being generally very intractable when not treated with regard to their primary cause.—*Irish Hospital Gazette*, March 1, 1873.

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*Troublesome Recurrent Stricture of the Urethra after Perineal Section.* — Mr. Erichsen, in some clinical remarks on this subject at University College Hospital, observed that, as was the case with some other operations, a good deal had been heard about the immediate effects of perineal section, but very little about its ultimate results. This case was therefore an interesting and instructive one. The operation had been performed sixteen years ago; the patient had instruments passed for some months afterwards. Since then there had been a complete relapse, and the stricture had now acquired to some extent a traumatic character. For some time past, small catheters had been occasionally passed with great difficulty. He now proposed to split the stricture with Holt's dilator.—*Brit. Med. Journal*, Feb. 15, 1873.

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*Simulation of Disease in a Scrofulous Patient.*—At one of the recent meetings of the Société Médicale des Hôpitaux, Dr. Lallier related a curious case of the above, which he had observed in his wards at Hôpital St. Louis. The patient had been several times before admitted into the hospital. The last time she presented scrofulous flexions and abscesses of the gums, and there existed besides several pultaceous patches of stomatitis and swelling of the submaxillary glands. Shortly afterwards a vesicular eruption on several parts of the body, and on the soft palate, was observed. On careful examination, M. Lallier discovered the existence of various small bits of a blackish substance around the teeth, and, by the help of the microscope, they were found to be cantharides powder. The patient

confessed that she had made use of bits of a blister plaster for the purpose of keeping up her disease. The chief feature of interest was the great difficulty of diagnosis, as the simulated disease had been grafted on a real strumous affection of the buccal mucous membrane. Such cases, according to M. Lallier, are frequently witnessed at St. Louis.—*Lancet*, Feb. 8, 1873.

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*Accidental Syphilitic Inoculation.*—Cases of accidental syphilitic inoculation in members of our profession have unfortunately been frequently recorded. Some have suffered very severely, and others have met, by the sad occurrence, with an untimely grave. In a memoir of M. Guersant, the eminent surgeon so long attached to the Hospital for Sick Children, recently read before the Surgical Society of Paris by M. Féréol, it is stated that the subject of the memoir was wounded in the right index-finger whilst operating upon a patient suffering from syphilis. The disease at once settled upon Guersant; he suffered from iritis, and subsequently had an attack of hemiplegia, which yielded to appropriate treatment. These ailments, however, undermined his constitution, and he at last died of cerebral congestion preceded by albuminuria.—*Lancet*, Feb. 1.

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*The Chemical Constitution and Toxic Characters of Metals.*—M. Rabuteau laid down, in 1867, the law that metals are more poisonous in proportion as their atomic weight is higher or their specific heat more feeble. He has addressed to the last meeting of the *Academie des Sciences* a note on the toxic properties of the salts of calcium in confirmation of that view.—*Lond. Med. Record*, March 5, 1873.

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*Insects' Feet as Carriers of Contagious Diseases.*—Prof. W. Kletzinski of Vienna has detected with the microscope an abundance of foreign particles in pure glycerine, into which flies had stepped, and from which they had succeeded in freeing themselves; thus vindicating the belief that flies may become carriers of contagious diseases. —*American Naturalist*, March, 1873.

*Death from Nitrous Oxide.*—A death from inhalation of this gas is stated in *The Med. Times and Gaz.*, Feb. 1st, 1873, to have occurred at Exeter on Jan. 23d.

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*The Advertisement of Medical Books in the Secular Press.*—The attention of the Council of the Royal College of Surgeons of England having been called to the frequent advertisement of medical works in the secular press—inserted with a view of advertising the author, rather than his works—the following motion was carried: "That the practice of frequently advertising medical works in the 'non-medical press' is, in the opinion of the Council of the Royal College of Surgeons of England, not conducive to the honor or dignity of the medical profession."

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*Dr. Bence Jones.*—We regret to announce the very serious illness of Dr. Bence Jones, who is suffering from ascites, attended with great anasarca of the lower extremities.

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Obituary Notice.—Died in Paris Feb. 24, 1872, of apoplexy, Dr. Marchal (de Calvi) aged 57. Dr. M. commenced life in the military service, rose rapidly to the first rank, and became one of the Professors at Val-de-Grace, when, with the inconstancy which characterized him, he resigned. M. M. was a constant contributor to medical journals, a brilliant writer and impressive orator. He was successively the editor of the *Gazette des Hôpitaux;* of the *Revue Chirurgicale Française*, which he inaugurated in conjunction with Begin, Velpeau, and Vidal (de Casis); the *Recueil des Memoires de Médecine et de Chirurgie et de Pharmacie Militaires;* became a contributor to the *Progrès Medicale*, and to the *Mouvement Medical*, and afterwards founded the *Tribune Medicale*, which he continued to edit up to the time of his death. It was on his return from the printing office of the last-named journals that he was attacked with cerebral hemorrhage which soon terminated his life.

M. M. was further the author of an interesting work entitled "Recherches sur les Accidents Diabétiques, et Essai d'une Théorie générale des Diabéte" (1864).

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Dr. Tuke has been industrious and thoroughly earnest in a good cause; he has done good service to the profession, in classifying and embodying in one volume a vast amount of scattered evidence concerning the influence of the mind upon the body, and in urging medical men to recognize the great importance of directing a more thorough attention to the subject of psychotherapeutics.—*London Medical Record*, March 5, 1873.

This admirable contribution to the science of mental physiology and pathology is addressed, says the author, to both medical and non-medical readers; and we cannot but think that the latter class will find as much to interest and profit them as the former. Dr. Tuke's style is so singularly clear, and his topic one so strongly appealing to every intelligent mind, that few will take up his book without becoming absorbed in its pages.—*Phila. Med. Times*, March 8, 1873.

This work is extremely interesting and instructive, and will prove useful for study and reference.—*Va. Clinical Record*, March, 1873.

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From a practical point of view, indeed, the work before us is decidedly the best in any language. On the whole, it is an admirable work, and well adapted to the wants of the practitioner. —*N. Y. Med. Journal*, Feb. 1873.

Throughout, the work is clear and very readable; indeed, the style is most happy. We cordially recommend it to our subscribers as being thoroughly practical, and containing much information which is not to be met with elsewhere.—*Canada Medical and Surgical Journal*, Feb. 1873.

We know of none which surpasses it, if any equal it, in the completeness and breadth of its scope, in the fairness of its discussion, or in the judgment displayed in committing and omitting. It seems to us to represent clearly and fully the general professional knowledge on the subject of which it treats, and we commend it most heartily to every practitioner who is so placed as to desire a single monograph to guide him at the bedside, as being probably the most complete and safest book of the kind in the language.—*New Remedies, New York*, Jan. 1873.

It would be out of place to review more fully a second edition of a work so well known and so fully appreciated as this.—*Glasgow Med. Journal*, Feb. 1873.

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**HENRY C. LEA—Philadelphia.**

# THE MEDICAL NEWS AND LIBRARY.

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## LECTURES.

*The Relative Frequency of Disease between the Right and Left Sides of the Heart; Degeneration of the Heart; its Causes and Means of Avoidance.* By CORNELIUS BLACK, M.D. (Continued from p. 54.)

IN my last communication I described the general and microscopic condition of the heart's muscular fibres when they have undergone degeneration from the long-continued action upon them of hypercarbonized blood, the result of defective aeration of that fluid. It was shown that the ultimate cells of which the fibrillæ of a muscular fibre are composed are permanently increased in their longitudinal diameter; that some of those cells are distended with a dark-coloured serosity; that both fibrillæ and fibres are less compactly and less firmly packed together than in their healthy condition; that their outlines are more irregular; that the sarcolemma exhibits various fissures or rents; and that the transverse and longitudinal striæ are more or less obliterated. It was further shown, that the epithelium of the endocardium is but very imperfectly developed; that the vessels lying immediately beneath its basement membrane are distended with dark blood, by which their usual interspaces are narrowed, and from which the endocardium itself presents a bluish or slaty-coloured ap-

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pearance; that a similar distension with dark blood affects the nutrient vessels lying upon the sarcolemma, giving the substance of the heart's walls also a dark-red appearance; and that this condition of the vessels and of the blood affects the external surface of the heart in like manner. The effect of these alterations in the ultimate structures of the heart's walls is, as was explained, to diminish the heart's contractile power, to favour dilatation of its cavities, and to render it liable to rupture, or to reduce its power to such a minimum degree that death, more or less sudden, takes place. The general appearance of such a heart, as the eye falls upon it *in situ*, was shown to represent it as apparently somewhat enlarged and of a bluish-red or slaty colour. Very different indeed is it, in this respect, from that of the heart when suffering from fatty degeneration.

A heart which has undergone fatty degeneration presents on its external aspect either a pale fawn-colour, or a mottled appearance from the intermingling of pale buff and more deeply coloured patches, or a faded hue of the healthy heart. It is soft, relaxed, and generally friable to the touch; its walls are thinned, and its cavities often dilated. Its paleness of colour, comparative bloodlessness, softness, laxity, and the attenuation and friability of its walls convey the impression that such a heart has been improperly nourished. This impression is further confirmed by the results of section and by the microscopic evidences which the muscular structure of the heart affords.

On section, the blade of the knife is rendered greasy—a condition due to the presence of fat, which is not found on section of a healthy heart.

On microscopic examination, the muscular fibres are seen to have undergone the following changes: When the fibres are diseased, those of the voluntary class have lost, either entirely or partially, their transverse and longitudinal striæ; and along the latitudinal axis of their fibrillæ the sarcous element has been replaced by a chain of molecules of oil. In some instances, the sarcous element of all the fibrillæ of a fibre has undergone this degeneration. In other instances, a part only of this element has been thus transformed. When the whole has undergone this change, a string of oil-globules from 1-6000th to 1-5000th of an inch in diameter occupies the sarcolemma; but when a partial conversion only of the sarcous element has taken place, mere points or dots of oil are scattered hither and thither, in broken line, along the longitudinal axis of the fibrillæ. Each such dot represents one or more cells which previously formed a part of a healthy fibril. Hence the number of such oil-dots present in a fibre is a measure of the degree of fatty degeneration which the fibre has undergone. When all the cells of a fibre have been converted, the mere points or dots of oil coalesce, and form oil-globules of the diameter before named. In this case, the fibre has lost its sharp, well-defined outline; and when many fibres thus affected lie together, they present the appearance of being blended into one indistinguishable mass. Where a part only of the cells has degenerated, the outline of the fibre is rendered irregular; and where this condition extends to many other contiguous fibres, the whole surface which they form presents these irregularities in dimly distinct and wavy outline. In the involuntary muscular fibres similar changes are observed.

Now, what has caused this conversion of the muscular fibre into fat? How has it been brought about? Has it a local origin only, or has the local change a constitutional cause?

In elucidation of the points which these questions involve it may be remarked, that the disease is essentially one which occurs in the later periods of life—that it nevertheless occurs in the young—and that when found in the heart it is generally found at the same time in other organs, as the liver, the spleen, the cornea, and the arteries.

That the disease results from the metamorphosis of the sarcous element of the muscular fibre, and not from the mere absorption of that element and the deposit in its place of fat in the ordinary process of nutrition, is indicated by the fact that the fat is contained *within* the sarco-

lemma of the fibre. When fat is deposited from the blood of an organ whose function does not produce fat, it is always deposited either *upon* the surface of that organ, or, if beneath the surface, upon the *exterior* of those elements of which the organ is composed. Hence the connective tissue is the seat of *deposited* fat. In this tissue we find it deposited beneath the pericardium, upon the exterior of the heart, beneath the endocardium, and also between the muscular fibres themselves. In neither of these situations does it constitute fatty degeneration. It should rather be called fatty deposit, or, in the language of Dr. Quain, "fatty growth." There is then but *one* form of fatty degeneration of the heart, and that form is expressed by the metamorphosis of the sarcous elements into fat, which is found within the sarcolemma itself.

According to the view already expressed, this substitution of fat for the sarcous element of the muscular fibre is not the result of the absorption of the one and the deposit of the other, but it is the product of the metamorphosis of the muscular element. Can then muscular fibre be converted into fat? No doubt it can. The pure fibrine of muscle has the same composition as blood-albumen—$C_{216} N_{27} S_2 H_{169} O_{68}$, with phosphates. All that is wanted here to derive from it the fat found in the sarcolemma of the muscular fibres of the heart is to separate these elements, to withdraw the nitrogen and sulphur entirely, and to recombine the carbon, hydrogen, and oxygen in different proportions. The less the vitality of a part the more easily does the combination of these elements give way—the more readily do they escape from the controlling power of the vital force, and become subject to simply chemical influences. After the age of forty the vital force begins, as a rule, to relax its hold upon the tissues, and thus to acknowledge that there is a limit to its existence—that life ends in death—and that, in the beautiful language of Bacon, "It is as natural to die as to be born."

When the tissues have reached this retrograde state of vitality—when, like the stones of an edifice upon whose face time has raised the first blisters of decay, and from whose junctions the mortar is beginning to crumble ere yet it falls, they have entered upon a downward tendency; the same active agents which ultimately complete the destruction of the moulder-ing edifice overpower here the feeble hold of life and effect the disruption of the muscular fibre into its ultimate elements. In doing this, oxygen and hydrogen, conveyed to the tissues by the blood, seize the nitrogen and sulphur, converting the one into ammonia and the other into sulphuric acid, and as such, either separately or in combination, hurry them by the natural outlets from the body. The carbon and a part of the oxygen and hydrogen are left behind; and these, combining in the following proportions, form the different fats which together constitute the oil-particles and globules found in the fattily degenerated fibres of the heart. These fats are the products of the combination of fatty acids with a hypothetical radical termed lipyle, with which they form respectively *oleine* and *margarine*. The former results from the combination of one atom of the oxide of lipyle —$C_3 H_2 O$ + one atom of oleic acid, $C_{36} H_{34} O_4 = C_{39} H_{36} O_5$, one atom of oleine; and the latter from one atom of the oxide of lipyle, $C_3 H_2 O$ + one atom of margaric acid, $C_{34} H_{34} O_4 = C_{37} H_{36} O_5$, one atom of margarine. To this group belongs *stearine;* but as I question its presence in the fatty product found in the sarcolemma of the degenerated muscular fibre, I give but its formula, which is the following: Oxide of lipyle, $C_3 H_2 O$ + stearic acid, $C_{34} H_{33} O_3 HO = C_{37} H_{35} O_4 HO$, one atom of stearine.

But why, it may be asked, if this doctrine is true, are the nitrogen and sulphur of the sarcous elements of the muscular fibre removed, and the other elements—carbon, hydrogen, and oxygen — left wholly, or in part, behind? The answer is, that there is an excess of carbon in the blood, and that there is a relative deficiency of oxygen. An excess of carbon in the blood prevents the oxygen carried by that fluid from combining with the carbon of the muscular fibre, and removing it as carbonic acid from the system.

It is well known that when the respired air contains 10 per cent. of carbonic acid the further exhalation of that gas from the lungs is prevented. In like manner, *when the blood contains more than the ordinary quantity of carbonic acid, the carbon of the tissues ceases to be acted upon by oxygen so as to be converted into carbonic acid.* It is shut up in the muscular fibre, where it combines with hydrogen and oxygen in the proportions necessary to form fat, which thus appears in the place of the sarcous elements.

How, then, does the blood acquire this excess of carbon? By deficient or defective respiration, or by an excess of carbon taken into the system in the food or drink, or by all these means together.

Deficient respiration attends the muscular debility which waits on age, sedentary habits, and disease. Defective respiration occurs whenever the air respired contains more than the one-thousandth part of carbonic acid by volume. An excess of carbon may be conveyed into the blood by the too exclusive use of a vegetable diet, and especially by the too frequent imbibition of alcoholic fluids. These facts account for the occurrence of fatty degeneration at all periods of life, but especially after the age of forty. They point to those who have passed the meridian of life, to green old age, to age shuffling in his slippers and pantaloons, to the diseased, the feeble of constitution, the studious, the emboweled in earth, the denizen of the workshop, the pent-up citizen, to the merchant confined in his ill-ventilated office, and to the drunkard, as the elected of its inheritance. They show, too, why fatty degeneration of the heart never, as a rule, exists alone; why it is always associated with fatty degeneration of other organs. Is it, then, a local or a constitutional disease? It is, strictly speaking, neither the one nor the other. It is a local expression of a particular condition of the blood, which age, habit, disease, or the exigencies of life have produced, but which claims no fixity of tenure in the constitution.

The age of forty arrives; it passes; the nervous system begins to lose by degrees its sensibility and its activity, and the muscular system its power. Innervation observes a corresponding decline; exercise is diminished; the respiratory muscles manifest less power in expanding the chest; less air than formerly enters the lungs; aeration of the blood is imperfectly accomplished; an excess of carbon accumulates therein. This accumulation of carbon may be either further favoured or entirely produced by the constant breathing of air vitiated by carbonic acid, or by food which is imperfectly digested and assimilated, and frequently by alcoholic drinks, the use of which has become too constant a habit.

Disease which prostrates both the nervous and muscular systems produces the same result. It, in fact, by debility of the respiratory muscles, reduces the efficiency of respiration to the level of old age. It may even do more than this. If the disease affects the lungs, the liver, the kidneys, or any great extent of the skin, the carbon usually excreted by these organs is thrown, if not wholly, at least in part, upon the blood, which may thus become so charged with it as to prevent the removal of the carbon of the muscular fibre during the process of the oxidation of the body.

Fatty degeneration of the heart finds, therefore, its predisposing cause in a diminished vitality induced by age, by habit, or by disease; its determining cause, in an excess of carbon in the blood, by which the removal of the carbon of its muscular fibre, in the oxidation of the latter, is prevented. Hence the recombination of the residual elements of its muscular fibre—carbon, hydrogen, and oxygen—in the form of fat, which now appears as globules or mere molecules of oil within the sheath of the sarcolemma.

The subjects of fatty degeneration of the heart are, perhaps, more frequently than otherwise the subjects of fatty deposit throughout the body generally. We know that, in many instances, there is a constitutional predisposition to the deposit of fat—that it passes from parent to offspring through many generations. With this constitutional proclivity to the deposit of fat is there, then, a similar constitutional tendency to fatty degeneration?

Not necessarily so. When fatty degeneration and fatty deposit are associated in the system, the decline of life has almost invariably been reached. At this period the conditions of life are, as I have already shown, favourable to the accumulation of carbon in the blood, and the consequent retention of carbon in the metamorphosing muscular fibre. Fatty deposit in the body favours immensely these conditions A thick layer of fat super-imposed upon the muscles is to their action as a break is to a carriage-wheel. It retards motion; it begets indisposition to exertion; it diminishes the oxygenation of the body. The respiratory muscles, labouring beneath a heavy burden of fat, cannot pull up the ribs and expand the chest sufficiently to admit a necessary quantity of air into the lungs. The test of the spirometer often declares that a less volume of air is expired under a forced effort by a chest thus encased in fat than by tuberculously diseased lungs under the same circumstances. The interchange between the carbonic acid in the blood and the oxygen of the air is consequently reduced below the healthy standard. What is the result? An excess of carbon in the blood; a diminished oxidation of the carbon of the metamorphosing muscular fibre; its retention within the sarcolemma; its recombination there with hydrogen and oxygen; and the replacement in consequence of the sarcous elements by fat. Fatty deposit, then, promotes fatty degeneration; but it does not prove that the latter is at all engrafted upon the constitution.

What practical bearing have these facts on diagnosis?

They show that a heart affected by fatty degeneration loses power in proportion to the degeneration which its muscular fibres have undergone. The extent of degeneration may be small, or it may be considerable. If small, the proportionate loss of power in the heart may not be appreciable. If considerable, it will be found in a modification of the heart's contraction.

A heart thus affected contracts feebly and often slowly. Its loss of contractile power diminishes the natural force with which the blood leaves the ventricles. The direct consequence is a reduction in the pitch of the sounds of the heart, which to the ear of an observer are rendered low and apparently distant. Another result of this feeble contraction is—a diminished volume of blood thrown by each effort of the left ventricle into the aorta; a diminished pulse-wave propagated to the distant arteries; a smallness, softness, and feebleness of the radial pulse. A heart thus reduced in power cannot maintain a vigorous circulation through the peripheral vessels. The blood moves slowly and in diminished quantity through the vessels of the brain, and a feeling of faintness, from the loss of the healthy stimulation and nutrition of the brain-substance, is the result. For the same reason the temperature of the extremities is generally low. If in this condition of the heart the body be raised suddenly from the recumbent to the erect position, death may occur instantly. The heart, scarcely able to maintain the peripheral circulation even in the recumbent posture, is utterly overpowered when it is suddenly required to throw the blood against the force of gravity to the brain. The blood fails to reach the cerebral vessels; they collapse; the patient faints, falls, and dies! This is the explanation of many deaths from fatty degeneration of the heart occurring in the early morning. The night is passed in sleep; the bladder during this time becomes distended; the patient awakes; he feels at once the desire to void urine; he rises before his system has had time to throw off the lethargy of sleep to obey the call; the heart fails to drive the blood in sufficient quantity to the brain; quick, almost instant death is the result.

*Such patients ought never to quit the recumbent posture immediately after waking—ought never to resume the erect position until the body has been refreshed and invigorated by the natural stimulus of food.*

At other times death is brought about in a different manner. Fatty degeneration, in islets or patches, has extended through the whole, or nearly the whole, thickness of the heart's walls; a sudden exertion is made by the patient; an increased effort is demanded of the heart; it responds to the solicitation conveyed to

it by an increased pressure of blood, but in doing so it ruptures;—the rest is known! As the degeneration of its walls progresses, and as the heart loses power, its cavities may become dilated, and its valves incompetent, thus leading to regurgitation through the orifices which they guard, and to a back-flooding upon the venous system of the body. If the mitral valve is thus rendered unable to close its aperture, the back-flooding is in the direction of the lungs; if the tricuspid, the back-flooding is in the direction of the general system. Hence, in connection with mitral incompetency, secondary consequences in the lungs, and their propagation backwards to the right side of the heart; in connection with tricuspid incompetency, secondary consequences in the brain, liver, stomach, spleen, kidneys, and the other parts of the body. Every organ thus flooded expresses its disturbance by perverted function. The converse of this is alike true. Every organ to which the fatty heart is unable to drive the blood in sufficient quantity has, in like manner, its function disturbed. In the erect posture the heart has more difficulty in filling the cerebral vessels than it has in effecting the peripheral circulation of the other parts of the body. The force of gravity opposes the ascent of blood to the brain. This opposition may be either moderately overcome, barely overcome, or not overcome at all by a fatty heart. The cerebral manifestations will be accordingly. When the force of gravity is moderately overcome, there will be no particularly marked cerebral disturbance. When it is barely overcome, rapid exhaustion on exertion, faintness, giddiness, spectral illusions, confusion of ideas, temporary paralysis, occur. When it is not overcome at all, death is the result. But paralysis is not always temporary. When not, it depends upon extravasation of blood at some point of the cerebral mass. At this point an examination of the cerebral vessels detects the same kind of fatty degeneration in their coats as exists in the muscular fibres of the heart. One or more such vessels have ruptured; blood has escaped; the pressure of it upon the surrounding brain-substance produces the paralysis. How has this rupture been caused? The power of the heart, by reason of the fatty degeneration of its walls, is not now equal to its power in health; the blood, therefore, has not been thrown to the brain with its original force, and yet one or more of the cerebral vessels have ruptured. The rupture is, notwithstanding, due to an increased pressure of blood upon the cerebral vessels; but this increase is rather *relative* than *real*. The heart has been weakened by fatty degeneration; the vessels of the brain have been weakened by the same cause. The latter are able to bear the pressure of blood produced by the heart under ordinary circumstances; they are able to bear so much pressure, and no more. The maximum of pressure which they can bear is below that of health, as the maximum power which the heart can exert is below the standard of health. But the heart may not have suffered degeneration in the same degree as the cerebral arteries. If, then, the heart is suddenly urged by any unusually exciting cause, it contracts for the moment with more energy; an increased pressure of blood is instantly thrown upon the cerebral vessels, and their rupture is the consequence.

Rupture, however, of the cerebral vessels may, according to Dr. Quain, have a somewhat differently determining cause. Instead of being due to the direct pressure produced by the *onward* flow of blood from the left ventricle, it is produced by *backward* pressure directed from the right side of the heart. According to the view of this eminent physician, the right heart is, by reason of its degeneration, unable to accomplish the pulmonary circulation sufficiently effectively to dispose of all the blood reaching it from the head and other parts of the body. A back-flooding therefore takes place upon the venous trunks. This propagates itself to the vessels of the brain, which become over-distended, and, remaining distended, ultimately burst. Meningeal apoplexy is more particularly the form of hemorrhage which is thus produced.

Without the coexistence of tricuspid or pulmonic valvular incompetency, I should scarcely expect this condition of the right

side of the heart to produce the effect upon the cerebral circulation which has been ascribed to it, because the power of the heart, and, probably, the frequency of its action, would be reduced in proportion to the degeneration of its muscular fibre; the volume and velocity of the blood sent to the brain would be reduced in a corresponding ratio; the return of blood from the brain would be in proportion to the supply; and, being below the quantity of health, the right cavities of the heart would not be flooded. Add, however, to the debility of the right heart tricuspid or pulmonic incompetency, and there is at once established a direct obstacle to the return of blood from the head; because the volume of blood leaving the right ventricle is, in the case of an incompetent tricuspid valve, projected in part into the right auricle, in which it meets the blood coming from the head and other parts of the body, and from which it causes a refluent wave upon the great venous trunks, thereby propagating its influence to the vessels of the brain, and thus causing their distension. In the case of pulmonic valvular incompetency, the blood, projected by every contraction of the right ventricle into the pulmonary artery, would, in like manner, fall back in part into the ventricle, in which it would meet the returning blood coming from the right auricle, and thus cause a back-flooding upon the great venous trunks and their tributaries, as already described.

But now comes the very important and practical question—Can fatty degeneration of the heart be diagnosed during life? In some instances of its existence it can. In other instances it cannot. Where the extent of degeneration is so limited as not to affect the contractile power and movements of the heart, it is impossible to diagnose with certainty the existence of this change. When, however, the degeneration is sufficient to weaken the natural force and movements of the heart, this altered condition of its muscular fibres admits of recognition.

The pure and simple indications which lead to this knowledge are—a feebleness of the heart's contraction; diminished impulse and sounds of the heart; great tendency to syncope, especially on exertion; a small, feeble, and often slow pulse; breathlessness on moving; early exhaustion on exertion; and a tendency to loss of temperature, especially in the extremities.

If with these conditions there exist the *arcus senilis* in the cornea, a large, soft, fat, pluffy body, and middle or advanced age, the heart's condition may be safely diagnosed as one of fatty degeneration.—*Lancet*, Oct. 19, 1872.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Remarks on the Resina Copaibæ as a Diuretic.*—Dr. Wilks, of Guy's Hospital, speaks (*Lancet*, March 22, 1873), with the greatest confidence of the value of the resin of copaiba as a diuretic. The ordinary copaiba has long been known for its action on the kidney, and is occasionally used in dropsy, but the nauseous taste of the oleo-resin has almost forbidden its employment. The oil, separated from the resin, is officinal, and is often prescribed in gonorrhœa instead of the compound substance. It is thought that the oil acts more especially on the mucous membranes, and is therefore useful in affections of the bronchial, vesical, and urethral surfaces. If this be so it is equally certain that the diuretic properties reside in the resin. Dr. Wilks has found it very difficult for patients to take the ordinary pharmacopœial drug, and almost impossible to get general practitioners to sanction its administration in private practice; he, therefore, has substituted for it the simple resin, and finds it equally or more efficacious. He gives fifteen or twenty grains in mucilage and flavoured water three or four times a day, and has had numerous cases showing its marked diuretic properties. There is now, in Guy's Hospital, a man who came in with ascites, and who, after taking numerous other remedies, was ordered the resin. The amount of urine was at once doubled in quantity, and now, after a few days, the fluid has almost disappeared. Dr. Wilks says he has lately had, as a private patient, a "drunkard builder," with cirrhosis of liver and enor-

mous ascites, for whom he likewise prescribed the resin; a diuretic action was at once effected, and the dropsy quickly disappeared. In heart cases, also, he has given it with great success. Lately there was in the hospital, a girl with mitral disease and considerable dropsy, who took the usual medicines without effect, and was then ordered the copaiba. It at once produced the desired result, and the fluid was dispersed. Dr. Wilks states that he has often given the remedy and failed; but, on the other hand, when it has succeeded, the result has been more striking than that arising from any other diuretic he has seen. He would wish it were placed in the Pharmacopœia, as it is not kept by chemists, although he is informed that it is used largely by perfumers, and the resin thrown away in large quantities as a waste material.

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### HOSPITAL NOTES AND GLEANINGS.

*Ligation of the External Iliac Artery; Unusual course of the Vessel.*—Sir Wm. Fergusson, on March 8, at King's College Hospital, tied the external iliac artery for aneurism, in a case which presented features of peculiar interest, both in its history and in the operation. Within the last few days an aneurism in the left groin of the patient, a man, had very rapidly increased and caused a large pulsating tumour in the pelvis. He came to the hospital only a week previously with all the indications of aneurism of the left common femoral artery; but he had only noticed a swelling there during the last two months. It was now as large as a fist, and the pulsation was very palpable. Sir William Fergusson at first thought of keeping him in the house for some weeks, and trying what could be done without operation. The tumour was frequently manipulated, with the result, apparently, of causing some giving way of the sac. The first incision through the skin showed that there was more vascularity in the parts than one would expect. The superficial veins were much enlarged and gorged, indicating the existence of pressure within or below, preventing the flow of blood towards the heart; and there was great venous hemorrhage. On going deeper, it was evident that a quantity of blood was effused into the tissues. On reaching the peritoneum, Sir W. Fergusson turned it up towards the mesial line, and here a novel feature presented itself; instead of the iliacus muscle lying as a whole before him, there was a prominence as conspicuous as a wrist when the hand is flexed, and very darkly coloured. It seemed as if the aneurism had burst at the back, and a great infiltration of blood had taken place in the substance of the iliacus. No trace of the artery could be seen, nor could it be felt anywhere. On pushing his finger deeply in towards the mesial line close upon the bladder, he came upon the artery, with little pulsation, in consequence of having nothing hard to rest upon, and quite at the inner side of the swollen iliacus. He passed the aneurism-needle under it, tied the ligature, and the pulsation in the aneurism immediately ceased. In his clinical remarks on this case, Sir William Fergusson said that he had tied most of the great arteries of the body, and had seen all varieties of their course, but he had never before seen the external iliac so distorted to the middle as here. Generally it was to be found easily enough high up. He first observed the extravasated tumour in the pelvis on the 6th, and then knew that no time was to be lost in operating.—*Brit. Med. Journ.*, March 15, 1873.

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*Case of Foreign Body in the Ear producing Convulsions.*—Dr. T. P. Walshe, surgeon to St. Mary's Eye and Ear Infirmary, Dublin, reports (*Irish Hosp. Gaz.*, March 15, 1873), the case of Anne Mc——, aged four years, who was brought to the infirmary with an abscess situated in the external meatus of right ear. The mother stated that the child was perfectly healthy until about ten days previously, when she suddenly got a fit, and had one almost daily since. Two or three days after the first attack she began to complain of pain in the ear, and had suffered very much with it since. On making an incision into the abscess a small quantity of pus came away. Ordered poultices, and the child to be brought back in two days. On again presenting herself, I learned she had had

two fits since I saw her, and that she had got a powder for them. I now strongly advised the mother to let her child come into hospital, but she refused. As there was some pus collected in the ear, I used the syringe to wash it out. I had scarcely begun doing so, when, along with the discharge and water, a grain of barley came away. Mother and child were both greatly surprised to see it, the latter declaring she knew nothing about it, or how it got there. Being anxious to know the result, I impressed on them the advisability of coming again, which they did in a week's time. The abscess was then healed, and the child had had no return of the fits. I asked them to come again, but, as they have not done so, I presume the child has quite recovered.

*Remarks.*—This case I consider to be one of great practical interest. Every medical man is aware of the habit children have of introducing foreign bodies into the ears and nostrils, very often forgetting all about them, as happened in the present instance. It shows strongly the advisability of carefully examining those cavities in cases of convulsions in children. The symptoms were clearly the result of reflex irritation produced by the grain of barley. It may further be remarked that the convulsions came on two days previously to any signs of inflammation; the reflex irritation being set up before the local.

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*Turpentine in Erysipelas.*—Dr. Leonardi reports (*Gaz. Méd. de Paris*, from *Journ. de Méd.*, vol. lv. p. 316) a case of a woman, aged forty-two, whose health was generally good, and who slept in the open air. On awaking she experienced severe pain in her head and neck. On the following day she had a shivering fit, followed by fever, and erysipelas appeared in the neck. On the second day the chest was attacked as well as the ears, which attained an immense size. M. Leonardi, on seeing the patient, prescribed the application of oil of turpentine twice a day to all the parts affected, and some aperient medicine. At the end of three days the affected parts had recovered their normal size, and the desquamation of the epidermis was the only trace of an attack of erysipelas so severe that it was at one time thought it would prove fatal.

He also gives another case of a scrofulous child, eight years of age, who, having been long exposed to the sun, began to suffer from pain over the whole right side of the chest. The next day the whole face was affected, and the nose and ears, greatly swollen, were covered with phlyctenulæ. The febrile symptoms were intense, the tongue dry, and all the symptoms of severe erysipelas of the face were present. Here, again, M. Leonardi prescribed embrocations of essential oil of turpentine twice a day, and internally some enemata with oil of turpentine. Several large lumbricoid worms were expelled, and on the fourth day the cure was complete.

The efficacy of applications of oil of turpentine, the author goes on to say, has been frequently verified in cases of traumatic erysipelas. The above cases show that it is equally serviceable in cases of spontaneous or idiopathic erysipelas.—*Practitioner*, March, 1873.

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*Gestation protracted to* 350 *days.*—Mr. R. J. Carey reports (*Lancet*, Feb. 22, 1873) the following case:—

Mrs. B., primipara, æt. 32, always regular, had morning sickness for the first time during the last week of February, 1872; quickened in July, and expected to be confined the last week in November. At this date the breasts were full, and for two or three days she had irregular pains, which then went off. The first week in January she again was out of sorts for two days, but nothing came of it. On February 8th (nearly five weeks after last date) she was delivered of a large male child, twenty-three inches long, with the head well ossified. Diameter—biparietal, four and one-eighth inches; occipito-frontal, five and one-third inches; occipito-mental, six and a-half inches. Hands and legs were large, but the body not.

Now, though morning sickness commenced in February, and, from the development of the child, conception must have taken place then, yet it is to be noted that the catamenia occurred three times subsequently in normal quantity, and at

the usual intervals. The last was in the last week of April; so that nine months and a week elapsed between the last catamenia and parturition, not between conception and parturition. If we reckon in February 24, 1872, pregnancy has lasted 350 days; but it may have existed a few days before the sickness commenced. The lady's illness in November, January, and now seems to support the opinion that throughout pregnancy, at every menstrual period, "a tendency to discharge the fœtus exists, but is resisted."

In the summer of 1871, I attended a patient who told me she was just two months out in her reckoning. The child weighed thirteen and three-quarter pounds. On four other occasions in London I have found pains go off, and have not been sent for again for about a month.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Quinia not an Oxytocic.*—Dr. A. D'Arcourd, ex-division surgeon of the French Army, now of Thebes, Alexander Co., Ill., writes us that for over 25 years he has used quinia in large doses for the cure of intermittent fever, in pregnant women as well as in other patients, without any symptoms of uterine disorder in the former resulting; and in 98 or 99 cases in a hundred the malarial affection has been controlled early, and such has been the result of this treatment in every latitude.

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*Thoracentesis.*—Dr. Austin Flint, in an interesting "Report of twenty cases of thoracentesis" (*Archives of Scientific and Practical Medicine*, March, 1873), lays down the following rules of practice as regards the employment of thoracentesis.

1. Thoracentesis should be resorted to without hesitation or delay whenever an accumulation of liquid or air within the pleural cavity compromises respiration sufficiently to endanger life, or occasion extreme suffering from the want of breath. This rule of practice applies to serous effusion as well as to empyema, and also to cases of pneumo-hydrothorax. Lives are sometimes saved by the operation. Complete recovery may follow; but the palliation of suffering, under the circumstances stated, furnishes a sufficient indication.

2. Thoracentesis is indicated in cases of pleurisy with considerable serous effusion, although the respiratory function be not compromised sufficiently to occasion any dyspnœa when the patient is at rest, provided the effusion do not diminish speedily under treatment with diuretics, hydragogues, and blisters. It is far better to resort to the operation under these circumstances than to persist in the use of the measures just named. These measures are perturbatory, debilitating, and often slow in their operation in the cases in which they prove effectual, whereas the removal of the liquid by puncture of the chest is immediate; it does not enfeeble the patient, and occasions no constitutional disturbance. Moreover, thoracentesis, resorted to early, has this great advantage: it is likely to be followed by an easy and full expansion of the lung. The long-continued condensation of lung by the pressure of liquid, the investment of the lung by layers of lymph which become dense with age, and adhesions from newly formed tissue, are obstacles in the way of this result.

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*Notes of Practice and Peculiarities of Treatment at the Bellevue Hospital, New York. Modification of Plaster-of-Paris Splint.*—There has been recently devised a modification of the plaster-of-Paris splint. It consists in laying strips of tin or wire gauze, about three-fourths of an inch in width, lengthwise of the limb. The flexibility of these strips is such that they readily accommodate themselves to any unevenness upon the surface, and yet strongly resist any lateral displacement. The advantages derived from these strips are, that an equally firm splint is obtained as when the plaster alone is used, and a very much lighter one.

*Sciatica.*— Some cases of this disease which had resisted a variety of treatment were cured at Bellevue Hospital, *almost at once*, by the hypodermic injection of morphia over the seat of pain, plunging

the needle deep into the tissues, perhaps to the depth of one or one and a half inches.—*Med. Record*, March 15, 1873.

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*The best Method for Removing the Upper Maxilla.*—Dr. J. J. CHISOLM, in a short article in the *Medical Record* (April 1, 1873), advocates Dieffenbach's operation, which appears to have been overlooked in the recent systematic treatises. This operation consists in making the incision in the median line of the face. Commencing at the root of the nose, an incision slits the nose and the upper lip in the median line. A short incision joining the first at right angles, extends from the root of the nose to the inner angle of the eye. The lower lid being drawn downwards, the knife is carried along the entire length of the conjunctival cul-de-sac, separating this lid from its orbital connection, and utilizing the entire length of the lower lid in the horizontal flap. When the flap, as defined by the vertical and horizontal incision, is dissected up, it will lay bare the entire front, and, if necessary, side of the face, without having divided any large vessel, or any important nerve-branch.

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*Excision of the Os Calcis.*—Dr. J. S. DORSEY CULLEN reports (*Virginia Clin. Record*, March, 1873) a case in which the entire calcaneum was removed with perfect recovery of the use of the foot in two months.

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*The so-called "Ovarian Cell."*—In a discussion in regard to this cell at a recent meeting of the Pathological Society of Philadelphia (*Phila. Med. Times*, April 12, 1873), Dr. TYSON said that he "was perfectly familiar with the cell spoken of as the 'ovarian cell,' which is nothing more than the ordinary compound granule cell formerly improperly called the 'exudation corpuscle' or 'inflammatory corpuscle' of Gluge, and for some time determined to be nothing but a fattily degenerated cell, in whatever locality found, and liable to be found in any locality."

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*Extraordinary Tolerance of large Doses of Morphia.*—Dr. R. M. OTIS gives an account in the *Bost. Med. and Surg. Journ.* (April 11, 1872) of the case of a woman who had used in four years ending Feb. 14, 1872, twenty-four ounces of sulphate of morphia by hypodermic injection.

In the same journal for March 6, 1873, he states that in the following year there was injected, hypodermically, in the same patient five and three-eighths ounces of the drug.

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*Medical Graduates in* 1873.—

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| University of Pennsylvania | 99 |
| Jefferson Medical College | 149 |
| College of Physicians and Surgeons, N. Y. | 104 |
| Bellevue Hospital Medical College, | 167 |
| Medical College of Ohio | 92 |
| Miami Medical College | 57 |
| Cincinnati College of Medicine and Surgery | 12 |
| University of Louisville | 75 |
| University of Syracuse | 6 |
| Rush Medical College | 61 |
| Atlanta Medical College | 14 |
| Missouri Medical College | 30 |
| College of Physicians and Surgeons, Baltimore | 17 |
| Savannah Medical College | 4 |
| Georgetown Medical College | 24 |
| University of Buffalo | 38 |
| University of Nashville | 69 |
| Indiana State University | 48 |
| McGill University (Montreal) | 35 |
| University of Bishop's College (Montreal) | 8 |

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*Fund for the Encouragement of Original Research.*—Prof. JOHN TYNDALL, during his recent tour in the United States, delivered thirty-five lectures, for which he received $23,100. After paying all his expenses out of this sum, $13,000 remained, which, before departing for Europe, Mr. Tyndall, with great liberality, placed in the hands of a committee consisting of Prof. Henry of the Smithsonian Institution, Prof. Youmans, of New York, and Gen. Tyndale, of Philadelphia, who are authorized "to expend the interest in aid of students who devote themselves to original research."

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*Philadelphia Obstetrical Society's Museum of Distorted Pelves, Obstetrical and Gynæ-*

*cological Instruments.*—At a recent meeting of the Philadelphia Obstetrical Society, it was decided to establish a museum of deformed and distorted pelves, and of obstetrical instruments possessing historical value or illustrating new methods of treatment. The Society solicits specimens, casts, or photographs of contracted pelves from members of the profession who may be willing to assist in forming a collection which will allow a wider and more comprehensive study of this subject.

Recognizing the fact that various instruments, designed for obstetric manipulations or for the performance of operations in uterine surgery, have been superseded by new and improved models, and now possess only an historical interest, the Society has determined to collect such instruments as illustrate the progress of this branch of our art in America. The Society urges upon inventors and surgical instrument makers the desirability of presenting to the Museum specimens of instruments and special mechanical contrivances which they may be desirous of bringing before the profession.

The Museum will be open to the inspection of all interested in the support and advancement of obstetrics and the kindred branches of medicine.

All objects for the Museum may be sent to Dr. J. V. Ingham, No. 1342 Spruce Street, Philadelphia.

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*New York Hospital Library* contains 9074 volumes, 408 of which have been added during *the past year.*

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*The Sanitarian.*—It affords us pleasure to announce the appearance of the first number of this monthly journal, under the editorial superintendence of Dr. A. N. Bell. "The purpose of this publication is to so present the results of the various inquiries which have been, and which may hereafter be made for the preservation of health and the expectations of human life, as to make them most advantageous to the public and to the medical profession." The current number contains 48 octavo pages of original, varied, and instructive matter from the pens of well known sanitarians, and the journal gives promise of well-filling a sphere of usefulness and benefit hitherto much neglected in this country.

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Obituary Record.—Died in New York, February 4th, of pneumonia, in the 42d year of his age, James Livingston Brown, M.D., President of the New York Obstetrical Society. Dr. T. Gaillard Thomas, in some feeling remarks made before the New York Academy of Medicine, said that in his death "not only this society but the profession of medicine met with such a loss as no calling is rich enough in able followers to look upon without concern." Dr. Brown's name is familiar to the readers of the *American Journal of the Medical Sciences* as that of the author of an admirable article on Pelvic Peritonitis and Peri-uterine Cellulitis, published in the number of that Journal for July, 1872.

—— in New York, on March 2d, aged 75 years, John Torrey, M.D., LL.D., Chief Assayer in the United States Assay Office in New York, and Professor of Botany in the School of Mines of Columbia College. From 1827 to 1854 Dr. T. was Professor of Chemistry and Botany in the College of Physicians and Surgeons, N. Y., of which institution he was a graduate.

Dr. Torrey earned distinction in chemical and botanical science. In 1824 he published the first volume of his "Flora of the Northern United States," and in 1838, in connection with his former pupil, Dr. Asa Gray, he began "The Flora of North America." He was a genial, kind-hearted man, an accurate observer, and an untiring labourer in the paths of science. In the discharge of his professional and public duties, he displayed unswerving fidelity and integrity.

—— at Richmond, Va., on the 13th of March, R. S. J. Peebles, M.D., Prof. of Chemistry and Pharmacy in the Medical College of Virginia.

—— at Harrisburg, Pa., on the 13th of March, aged 67, William Wilson Rutherford, M.D., the oldest practitioner in Harrisburg. On the announcement of his death the Dauphin County

Medical Society passed appropriate resolutions, recording their appreciation of him who "had been our associate, our president, and our representative to the State and National medical associations—thus filling all the positions of honour and confidence in our gift."

—— in Mobile, Alabama, on the 31st of March, in the 69th year of his age, Josiah Clark Nott, M.D, formerly Professor of Anatomy in the University of Louisiana, and Professor of Surgery in the Medical College of Alabama.

Dr. Nott was an eminent surgeon and gynæcologist, and was a frequent contributor to the pages of *The American Journal of the Medical Sciences* and other journals. He was the author of a monograph published in 1866 "On Bone and Nerve Surgery," and conjointly with Mr. Gliddon wrote a work on the "Types of Mankind," which has enjoyed considerable reputation. At the close of the war Dr. Nott removed from Mobile to Baltimore, and soon afterward to New York, where he remained until a short time before his death. His talents and skill caused his advice to be extensively sought after.

## FOREIGN INTELLIGENCE.

*Skleroderma.*—The Vienna correspondent of the *Irish Hospital Gazette* (Feb. 15, 1873) reports two cases of that very rare disease, skleroderma, or sklerema adultorum. Hebra objects to the latter term, as the disease occurs in children quite as frequently as in adults. The extreme infrequency of this affection may be gathered from the fact that Hebra has only seen some twelve or thirteen cases, and Dr. Neumann (whose book is so well known) has only seen six, including these two, amongst the thousands of skin diseases which he has had the opportunity of witnessing.

The first case was a young girl, aged 15. The face, hands, and forearms were the parts affected. The integument covering the face was of a brown colour, and presented a smooth, shining surface, giving one the idea of its being in an atrophied condition, and looking as if it had been drawn too tightly over the face, thus effacing most of the natural folds, and producing a peculiarly stiff and unvarying expression. The fingers of both hands were considerably contracted, giving to them a clawed appearance. The condition of the integument covering them was similar to that of the face, except that the discolouration partook more of a purple hue.

The second case was that of a servant-maid, aged 37. In this instance the disease was confined to the upper extremities; it had commenced, two years and a half previously, with a feeling of tension in the affected parts. On the right extremity the disease was in a more advanced state than on the left; a band, about nine inches long by one and a half wide, of a peculiar looking tissue, somewhat elevated, with a smooth, shining surface and of a brown colour, extended to about an equal distance above and below the elbow-joint. It was situated on the outer side and towards the flexor aspect of the limb, which it prevented from being fully extended, as a cicatrix caused by a burn would have done. On the opposite limb the disease was not in such an advanced stage; the band, which was on the ulnar border, was softer to the feel, and much lighter in colour. The secretion of the diseased portions of skin was diminished, though not altogether abolished.

These two cases are, I think, the more interesting, as they exemplify two forms or stages of the disease. In the first case the diseased portion of skin was atrophied; in the second it was raised above the surrounding surface. Hebra has named these two forms sklerema atrophicum and sklerema elevatum respectively. This division he regards as of some practical importance as regards prognosis, the former being perfectly incurable. The treatment in both cases consisted in simply keeping the parts warm by means of steam baths, or wrapping the limbs in gray plaster or caoutchouc cloth. Electricity has been very much praised as a means of treating this affection, and cases of cure have been reported, but the disease is so easily confounded with others, that Dr. Neumann doubts the correctness of the diagnosis, especially as they were seen by no der-

matologist. Hebra believes the disease to be identical with that described by Addison (New Syd. Soc. 1869) as a form of keloid, and it is sometimes spoken of here as Addison's keloid. Professor Hebra, however, objects to this name, as it implies some connection with true keloid, whereas there is none. Fortunately there happens to be a very well-marked case of keloid in the hospital at present. The patient came into hospital to be treated for psoriasis, and as he walked into the clinic without any clothes on (as is the invariable rule here), the all-observing eye of the Professor at once caught sight of a well-marked keloid, situated over the second bone of the sternum, about three inches in length by one quarter of an inch in breadth.

—

*Subcutaneous Injection of Atropia in Acute and Chronic Rheumatism.*—Dr. De Cavazzani, in *Lo Sperimentale* for Jan. 1873, gives the results of his experience of the subcutaneous injection of atropia in cases of articular rheumatism, both acute and chronic. The solution which he generally uses is composed of 0.05 *gramme* (about three-fourths of a grain) of atropia, 6 drops of sulphuric acid, and 100 *grammes* (about 3½ ounces) of water. Of this he injects from six to fifteen or twenty drops, according to the condition of the patient and the results obtained. The injection is made in the neighbourhood of the affected joints; and, as soon as the symptoms have been alleviated, the use of the atropia is stopped. He relates, from among the cases which he has treated in this way, eight of acute and three of chronic rheumatism, in which the treatment was attended with success. In one of the cases, where symptoms of cardiac disease had set in, an injection of thirty drops of the solution over the course of the par vagum (and a blister to the præcordium) had the effect of arresting these.—*Brit. Med. Jour.*, March 8, 1873.

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*Epilepsy treated by Sulphate of Zinc.*—Dr. Oxley related to the Liverpool Medical Institution (*Brit. Med. Journ.*, March 22, 1873), a case of the successful treatment of epilepsy by sulphate of zinc where bromide of potassium had failed. The girl, aged ten, in good health, had three or four fits in a day. Bromide of potassium, in ten, and afterwards twenty grain doses, three times a day, had no effect. Sulphate of zinc, in doses of three grains three times a day, was given. She had one slight fit, after which she was free for several days, when the fits returned. The medicine was renewed, and the fits entirely left her. Dr. Oxley had never before seen sulphate of zinc of any service in epilepsy, but bromide of potassium had proved very beneficial.

—

*Crystallized Nitrate of Silver in Chronic Catarrh and Ulcer of the Stomach.*—Dr. Turk, of Wiese (*Med.-Chir. Centralblatt*, No. 1, 1873), says that he has given nitrate of silver in several cases of perforating ulcer daily in the proportion of one grain to four ounces of distilled water, to which were added ten drops of tincture of nux vomica, and has obtained the best results—where acetate of lead, preparations of alum and opium had no effect. On the administration of this remedy, hæmatemesis ceased, and all other symptoms improved with unlooked-for rapidity, so that (except some slight ferruginous treatment) no other drugs were needed, and complete cure followed. In cases of chronic sickness during pregnancy, chronic catarrh and cramps of the stomach, especially in hysterical women, he has found nitrate of silver, even in smaller doses, such as a quarter of a grain, most efficacious.—*Brit. Med. Jour.*, March 8, 1873.

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*Death from Chloroform.*—Another death has just occurred at St. Thomas's Hospital, London. The patient, a boy aged 15, had administered to him about two drachms of chloroform prior to the examination of his arm, which had recently undergone spontaneous fracture. His viscera were found to be healthy. "He seemed to have died from syncope during his recovery from the anæsthetic."—*Brit. Med. Jour.*, March 22, 1873.

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*Methylene Ether.*—Mr. T. Easter, dresser in the eye wards at Guy's Hospital, states (*Brit. Med. Journ.*, March 22, 1873), that methylene ether has been administered ten

times, for operations on the eye, at Guy's Hospital. In five of the ten cases, there was vomiting within five minutes of its being inhaled. The vomiting was slight in only one of the five cases. Insensibility was generally produced in four minutes; two, three, or four drachms of the methylene ether being used to attain that state. Struggling and excitement occurred very much as with chloroform. Two patients, who had taken chloroform badly, were readily rendered insensible by the methylene ether. As a rule, the pulse became rather stronger; in one case it became very irregular. The operations were of the following kinds: On the eyelids, 3; on the iris, 4; on the cornea, 1; on the sclerotic, 1; on the capsule of the lens, 1.

—

*Twin Pregnancy after Ovariotomy.*—Dr Olier, of Orleans, records (*Gaz. des Hôpitaux*, Dec. 10, 1872), a case where a patient became pregnant three months after ovariotomy, went on to the full term, was safely delivered of twin boys, and recovered well. The abdominal wall did not suffer at all, notwithstanding a twin pregnancy so soon after ovariotomy.—*London Med. Record*, March 26, 1873.

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*Natural Selection and Sexual Selection.*—M. Edmond Perrier, of the Museum of Natural History of Paris, in an article in the *Revue Scientifique* (March 15, 1873), ably discusses these theories of Darwin, and gives the following as his conclusions:—

The theory of sexual selection has been devised to fill up a void in the theory of natural selection. Neither of them suffices to explain the enormous variety of animal species. Nevertheless it cannot be regretted that these hypotheses have been advanced; they have given rise to two essentially original works in which the animal kingdom has been shown in an absolutely new light. These works have made a deep impression on scientific minds; they have opened new and most expanded fields for research. Their influence will long impress itself on the ideas of naturalists.

Darwinism will, doubtless, perish, but the name of Darwin will nevertheless remain as one of the greatest in science and modern philosophy.

—

*Smallpox in Vienna.*—From the beginning of the present year, to February 22d, there were 2564 cases of smallpox in the hospitals and private practice; of these 1499 recovered and 537 died. We are happy to learn that these figures denote some diminution in the severity of the disease.

—

*Trichiniasis.*—In the course of a recent discussion on trichiniasis in the Medical Society of Magdeburg, twenty-six physicians, who were present, stated that they had, under their care at the time, a hundred of the inhabitants of the town, who had purchased pork containing trichinæ, from the same slaughter-house within the same week, and had eaten *it nearly* raw.

—

*Progress of the Reintroduction into England of Ether as an Anæsthetic.*—Mr. Jonathan Hutchinson, Senior Surgeon to the London Hospital, in the course of a clinical lecture which he recently delivered, said: "I am strongly of the opinion that we ought, with the exception of a few cases, to allow ether to supersede chloroform."

—

*The Medical Society of London* celebrated its centenary on March 10.

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*Bogus Diplomas.*—It has just come to light that during the last few years a large trade has been carried on in forged diplomas, purporting to be from the University of Marburg; no less than forty persons in England having purchased the worthless documents.

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*The Leprosy of the Bible*—Dr. Hebra, the great dermatologist of Vienna, has expressed the opinion that the leprosy of the Bible was scabies (itch), and that Naaman's cure by washing in the Jordan was due to the amount of sulphur which the water of that river contains.—*London Med. Record*, March 26, 1873.

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We have already alluded incidentally to the independence which marks our author's work. He has observed and thought for himself, and the result of his observations accords with that of many other surgeons at the present day. If we mistake not, his book will do much to dissipate some old and baneful prejudices. The laborious way in which he has collected statistics, both from his own practice, and that of others, and the original conclusions that he has drawn from them, deserve much praise. Its excellence consists in the number of valuable facts, of well selected cases, and of sound opinions, which it contains.—*British and Foreign Med.-Chirurg. Review*, April, 1873.

Mr. Bryant's work well deserves the careful study of students and practitioners, and as a text-book we think it is likely to be quite a general favorite.—*Cincinnati Clinic*, March 22, 1873.

With this "Practice of Surgery" we are much pleased, and commend it to the notice of students and practitioners as a work containing a great deal of information respecting the diagnosis and treatment of surgical diseases and injuries. We have no hesitancy in recommending it as one of the best of the less than half-a-dozen works from which the student should select his text-book in surgery.—*Am. Journ. Med. Sciences*, Apr. 1873.

It contains an immense deal of information. Most of the surgical principles taught are unexceptionable; its illustrations are nearly all fresh, some of them instructive. It is the work of an earnest laborer, an honest man, a surgeon who loves his work for its own sake.—*Edinburgh Med. Journal*, April, 1873.

Mr. Bryant's work is an entirely new one. We have carefully compared his work with that of Mr. Erichsen, and find that they are both of great value, and that if one of them (Erichsen's) is superior to the other, in being larger, and therefore giving more details on diagnosis and operations, the other (Bryant's) has the advantage of being a more elaborate exponent of some of the recent advances in surgery. In many respects we should say they complete each other.—*Phila. Archives of Scientific and Practical Med.*, Mar. 1873.

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*NUMBER I., FOR APRIL, JUST READY.*

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## LECTURES.

*The Relative Frequency of Disease between the Right and Left Sides of the Heart; Degeneration of the Heart; its Causes and Means of Avoidance.* By CORNELIUS BLACK, M.D. (Continued from p. 71.)

*The Prognosis in the forms of Heart Disease considered.*

The conditions of every case of heart disease afford ground for the formation of an opinion as to its ultimate issue. If these conditions are rightly interpreted, the result should seldom be at variance with the prognosis expressed. To the patient and friends it is of the utmost importance that there should be no misinterpretation of symptoms—no promising, from ignorance or carlessness, a continuance of life where it is impossible for life to be long maintained—no shadowing forth of sudden death where no immediate danger to life exists. In the one instance, fancied security procrastinates the adjustment of family interests, worldly pursuits, and the calm consideration of the prospect of death. In the other instance, the unfounded impression of early dissolution begets unnecessary alarm, unfits both mind and body for the warfare of life, and continually invests the case with sorrowful forebodings, anxious solicitude, and wearisome suspense.

In the interests of his patients, and for the reputation of himself, the physician

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should seek to interpret aright the indications which every case of heart disease affords, and to deduce therefrom a prognosis which is justified by a knowledge of the physiology and pathology of the heart, by judgment, and by the light of experience and of facts.

The dogma that *a diseased heart predicates early death* no longer retains its hold on the mind which has been accustomed to watch its diseases through all the phases of incidence, rise, climax, decline, and consequence. The heart may be diseased, and no danger whatever to life may exist. It may be affected, and danger may attach only to its somewhat distant future. It may suffer, and death is constantly at hand.

These facts are legitimate deductions of knowledge acquired by observation, sanctioned by reason, and confirmed by experience. They teach that the degree of danger in heart disease is determined by the particular part of the heart which is affected, and by the nature and extent of the disease which exists. A mere roughness from exudation of a part of the endocardium of the left ventricle which does not interfere with the free action of the mitral or aortic valves, but which is sufficient to alter the character of the first sound of the heart, is not of itself productive of any danger whatever to life. I have known this condition of the heart exist for a period of twenty years without it advancing one step, and without its producing the least trouble or inconvenience to the patient.

*In such a case the prognosis is always favourable as to the continuance of life. The patient cannot die suddenly from this condition of the heart alone.*

Let, however, middle age be passed, and this condition of the endocardium may gradually and imperceptibly extend to the mitral or aortic valves, or to both; or these valves may, from the insidious stealth of natural degeneration, shrink, just as the features of the face become shrivelled by age, so as to render them no longer able to effectually close their respective apertures.

*When valvular incompetency has thus been established, the case passes in prognosis from the category of safety to that of more or less danger.*

The blood cannot be diverted in any degree, from its natural course in its passage through either the left or the right side of the heart, without establishing a danger which is either present or more or less remote. Present danger is more particularly caused by valvular incompetency on the left side of the heart; slower danger by valvular incompetency on the right side of the heart. Sudden death is the legitimate termination of the former; a lingering death the general issue of the latter.

When sudden death occurs in heart disease, it is due to one of three causes—either to the sudden breaking of the column of blood in the aorta, or to the diversion of the blood from its natural course as it is being projected from the left ventricle, or to the failure of the heart to contract.

The column of blood may be broken in the aorta by great incompetency of the aortic valves, which fail to afford a firm basis of support to the charge of blood which has just been thrown into that vessel by the left ventricle. From the incompetency of the aortic valves, a fissure or hole is left when they have been brought into the closest approximation of which they admit, and through this hole the blood, thrown into the aorta, may run back into the ventricle so rapidly and in such quantity that the column in the aorta is suddenly snapped, the further flow of blood to the brain is at once arrested, the vessels of the brain instantly collapse, the patient faints, falls, and dies!

The blood may, as it leaves the left ventricle, be diverted from its natural course by an incompetent mitral valve. When the incompetence is great, the greater portion of the charge of blood may, on leaving the left ventricle, regurgitate into the left auricle; whilst the smaller portion does not reach the aorta in sufficient quantity and force to pass to the brain. The vessels of the brain therefore collapse, as in aortic incompetency, and the patient dies.

Whenever the mitral valve is incompetent, a part of the ventricular force is ex-

pended in driving the blood back again into the left auricle, and a corresponding reduction of force is felt by the blood thrown into the aorta. It is easy to see that the expenditure of force in the former act may be so great, and that the force exerted upon the blood in the aorta may be so weak, that the blood cannot reach the brain.

Between, however, the two incompetencies—that of the aortic and that of the mitral valve—it may be remarked, that danger of sudden death is greater in the former than in the latter lesion. Incompetency of the aortic valves often produces sudden death; incompetency of the mitral valve less frequently. The reason why sudden death is seldom the result of mitral valvular incompetency is due to the fact, that the aortic valves are generally competent in such cases. The same incompetency of the two valves seldom coexists; or, if both valves are incompetent, the mitral incompetency has acquired a marked precedence in extent over the aortic. Hence, in mitral incompetency, whatever quantity of blood is thrown into the aorta finds, as a rule, a firm support in the aortic valves to rest upon, so that the column of blood, however small, is maintained in that vessel, and reaches the brain in sufficient quantity to prevent a fatal collapse of its vessels.

*It therefore follows that the prognosis, as regards sudden death, is less favourable in aortic than in mitral incompetency.*

Incompetency of the latter valve is rather a conservator of the integrity of the aortic valves, because less force is exerted upon the latter valves by reason of the expenditure of ventricular force through the mitral valve. This loss of force upon the aortic valves is to some extent made up by hypertrophy which the left ventricle undergoes from the too frequent action excited by regurgitation; but it is a question whether, even with acquired increase of power, the force now exerted upon the aortic valve equals the original force upon the same valves when the mitral valve itself is quite healthy. The additional power acquired by the heart from hypertrophy is spent upon the two valves in the same relative ratio as the original power. If the diseased mitral valve received one-half or two-thirds of the original force of the left ventricle, it will also receive one-half or two-thirds of the additional force acquired by hypertrophy. Thus, then, the force exerted by the left ventricle upon the blood in the aorta, less than natural in the very early stage of mitral incompetency, does not exceed the normal force when the ventricle has undergone hypertrophy. The evils, therefore, of mitral incompetency are not propagated in the direction of the aorta—not *with* the current of blood leaving the heart, but *against* that which is reaching the heart. The aortic valves are thus spared; but the evil effects reach the lungs, and are thence propagated to the right side of the heart. Congestion of the lungs is the first evil effect produced in the retrograde course of the circulation by mitral incompetency; then back-flooding upon the right ventricle, which becomes hypertrophied. From the former arise hæmoptysis, pulmonary apoplexy, inflammation of the lungs, but much more frequently *simple hypertrophy of the pulmonary tissues of the lower lobes;* from the latter, congestion of the brain and its consequences, venous congestion and enlargement of the different organs of the abdomen, and general dropsy. Thus, although danger is more imminent in aortic valvular incompetency, yet it is not more certain than in mitral incompetency. The one may kill at a stroke; the other kills more slowly but not less certainly.

In delivering his prognosis as to the probability of sudden death, the physician must be guided by the condition of the mitral and aortic apertures. If they are not effectually closed by their respective valves, the blood is either diverted from the aorta, or it is allowed to fall back into the left ventricle. In either case the natural character of the pulse is altered. Where mitral incompetency exists, the pulse is irregular, unequal, and probably intermittent. Where aortic incompetency is present, it is, as a rule, regular; but no sooner does it rise beneath the finger than it suddenly recedes from it and is gone again. When, however, the aortic incompetency is great, the pulse, in addition to

its peculiar character of receding suddenly from beneath the finger, is also intermittent. Now, whenever in valvular disease these characteristics of the pulse are strongly pronounced, death may occur suddenly. Still, experience shows that sudden death is not the usual termination of mitral incompetency, the reason of which I have already assigned. Death, however, may and does occasionally occur suddenly in this condition of the mitral valve.

*Hence the prognosis with respect to sudden death should, in mitral incompetency, be, possible—in aortic incompetency, probable.*

Now, as certainly as the characters of the pulse thus indicated in valvular disease bespeak the *possibility* or the *probability* of the occurrence of sudden death, so certainly does a regular and equal—equal as to its rise and fall—pulse declare the impossibility of such an occurrence when the muscular walls of the heart are healthy.

*Hence, whatever amount of mischief exists on the left side of the heart, death cannot occur suddenly so long as the pulse preserves its regularity and equality.*

But aortic and mitral incompetency sooner or latter end in death, because an incompetent valve on the left side of the heart *never*, as a rule, regains its normal condition—*never* again confines the blood to its natural course; but it, on the contrary, gives rise to secondary consequences, which it increases and perpetuates until death. To the right side of the heart these remarks do not apply with equal force. Here the tricuspid valve may become temporarily incompetent from the back-flooding upon it caused by inflammation of the lungs. As soon as the inflammation has been subdued and the vessels of the lungs have been relieved, the backward pressure of the blood is taken off the right cavities of the heart, and the tricuspid valve returns to its normal competence.

Very different are the effects of constriction of the mitral and aortic apertures. The very cause which increases the incompetency of their valves tends to remove the constriction. In the latter condition the blood is opposed in its onward flow from auricle to ventricle—from ventricle to aorta. At each point it has to struggle through an aperture narrowed by disease. In doing so the tendency of the effort is to widen the aperture, and to restore it to its natural diameter. No sooner has the constriction occurred to the extent of preventing the natural quantity of blood from passing these valves than a retrograde influence is propagated from the mitral valve to the lungs—from the aortic valve to the left ventricle. The former results in dilatation and subsequent hypertrophy of the left auricle, and in an excess of blood in the vessels of the lungs; the latter in a continual teasing of the left ventricle to contraction. The blood can neither enter the left ventricle nor yet leave it in sufficient quantity. The ventricle contracts upon an insufficient quantity of blood, but it does not empty itself; a small portion of blood remains in it when it has completed each individual effort. The presence of this remaining portion of blood immediately excites the ventricle to a repetition of its contraction, and, this occurring more frequently than natural, the nutrition of the heart's walls is increased, and hypertrophy is the result. Hypertrophy is not, therefore, induced for the purpose of overcoming the valvular obstruction, but it follows *as a necessary consequence* of the increased action of the ventricle. In this respect it obeys the general law—that increased action leads to increased nutrition, to enlargement, to hypertrophy. Of the truth of this, the increased development of the leg of the opera dancer and of the arm of the blacksmith are examples.

Now, can a heart thus affected by constriction of its mitral or aortic valves, or of both, and by hypertrophy, ever recover its normal condition? This much may at once be said in answer, that, if it cannot entirely recover its natural condition, it may at least undergo so great an improvement in every respect that it may ultimately discharge its duty without trouble, without unusual effort, and with the same ease and regularity as in its healthy state. Constrictive valvular disease is one of the diseases of the early period of life, and the result of inflammation. Changes thus

produced in early life, time will enable the system to rectify. At this period of life nutrition is active; waste is active; the tissues are more instable than in perfect manhood; molecular change is the more readily brought about. If a repetition of inflammation can be avoided, the natural efforts of the system will, in the course of a few years, effect the absorption of the exudation, relieve the constriction of the valvular apertures, allow the blood to enter the left ventricle and to leave it in sufficient quantity, and in this way may restore the natural condition of the heart This condition re-established, the hypertrophy gradually reduces until the heart at length returns to its natural size. The cause removed, the effect disappears. I am aware that this doctrine is opposed to the general opinion—that the heart once hypertrophied is never reduced to its original size. To this opinion I oppose the result of my own experience, which prompts me unhesitatingly to declare that hypertrophy thus induced in early life will, and does, pass away on the removal of its cause. That which the system is capable of effecting in early life cannot be accomplished after middle age—the practicable of youth becomes the impracticable of more advanced years. It follows this statement that the prognosis to be given in a case of the nature just described is—*That perfect recovery may occur in youth; that it cannot be effected after middle age.* Whilst the body is yet young we ought to have unbounded faith in the efforts of nature. Her power is marvellous; and the results which she achieves often astonish our belief and put to shame our ignorance. She abhors "non-naturals," as the ancients have it, and she ever strives to substitute for them the "naturals." It is not natural to have constricted mitral and aortic orifices and an enlarged heart. She will, therefore, endeavour to remove them. If age and the conditions of life favour her efforts, she may accomplish her task. If they oppose, she will fail, and the grave will, ere long, receive the subject of her unavailing exertions.

The heart may suddenly cease to contract from mechanical arrest, or from innate failure of action in its muscular fibres. An accumulation of fluid in the pericardium—whether of serum, or of pus, or of blood—may produce such an amount of pressure upon the surface of the heart that it can no longer beat beneath the load which oppresses it. Here it will have given previous indications of its difficulty; and, if that difficulty be properly appreciated, the prognosis delivered will always convey the expression of *danger.*

The heart may again suddenly—in an instant—fail to deliver its charge of blood, so that death occurs unexpectedly and at once, or death may be preceded by a short period of urgent symptoms which have abruptly and instantly broken in upon the patient's unsuspected and accustomed health. When death thus occurs at once, the left ventricle is instantly paralyzed in its action, either by degeneration of its muscular fibre to such an extent that it can no longer respond to the incident impression caused by the presence of blood in its cavity, or by an increased amount of labour suddenly cast upon it, which it has not the power to accomplish in consequence of the extent of degeneration which its fibres have undergone. When death occurs thus suddenly degeneration of the muscular fibres will generally be found to have taken place pretty equally throughout the heart's walls. When, however, death has been preceded by a short period of urgent symptoms, this general degeneration of the heart's fibres may not exist. Certain portions of the left ventricle will generally be found to have undergone this change to such a degree that the heart ruptures at one or other of these points in its effort to discharge its blood into the aorta. The heart having by degeneration lost its power of contracting at particular points, and retaining its power of contracting at other continuous and contiguous points, traction, which cannot be correlated, is made upon the former points, the muscular fibres throughout the thickness of the heart's walls break in consequence, blood pours through the rent into the pericardium, and death quickly follows.

In every case of the degeneration of the heart's muscular fibres, whether that degeneration takes the particular form which I have described as the result of hyper-

carbonized blood from defective ventilation, or that of fatty transformation, the prognosis is *unfavourable.*

If, however, the early stage of degeneration from defective ventilation be recognized, its condition may be remedied, and its evil consequence avoided, by the resolute removal of the cause; but if the fibres of the heart have undergone, to any considerable extent, that change which I have shown to be characteristic of this particular form of degeneration, there is no hope of a long continuance of life for the patient.

Of fatty degeneration of the heart an equally unfavourable prognosis may be expressed. It is essentially a disease of the degenerative period of life. It occurs more particularly when the reparative powers of the system are reduced—when the vital force is less able than formerly to withstand the power of opposing chemical influences—when every organ, every structure, has in consequence lost the stamp and vigour of youth, and is passing by slow and almost imperceptible change to decay. In such a condition, under such circumstances, the transformed muscular fibre cannot undergo retransformation—cannot recover its pristine state. Oil cannot be converted into fibrine, although fibrine has been converted into oil. The latter cannot recover the elements which the former has lost; it cannot ascend from its present to a higher organization. The complex structures degenerate; but the simple structures no longer ascend the formative scale. The tendency of the structures of the heart is in a downward direction, which art may delay, but which it can never entirely arrest. The molecules of oil which now replace the fibrine in the sarcolemma of the muscular fibre will there remain; they will be added to, slowly it may be, from the influence of art, but nevertheless certainly, by the metamorphosis of other portions of the sarcous elements; and they will by each addition weaken more and more the structures of the heart, until the labour imposed shall exceed the power to accomplish, when death more or less rapid will ensue.

It is perhaps possible, when in early life fatty degeneration supervene on other disease, that the transformation may be arrested, and that the heart, if not too much damaged by this change, may be enabled to fulfil its duties for an indefinite time. Whether or not this arrest of transformation is ever followed by the removal from the muscular fibre of the matter transformed is a problem which has not yet been solved. That which is impracticable in after life is often practicable in early age. For this reason I readily admit the power of youth, rising triumphantly from other and temporary diseases, to arrest the transformation in question; and I do not deny that it may be competent to do still more—to remove the products of such transformation, and to replace it by healthy muscular fibre.

*The prognosis, then, which necessarily flows from these views, expresses danger of sudden death in every case in which the heart's fibres have undergone fatty degeneration—impossible recovery after middle age—possible recovery in the early periods of life,*

The heart knows not only a sudden death, but it knows a death which is always slow. This arises from disease of its right chambers. Seldom indeed are these chambers the seat of inflammation, often of degeneration. Their diseases may be either primary or secondary: primary from tissue-degeneration of their walls; secondary from the mechanical stretching of their walls caused by backward pressure of blood from the lungs through the pulmonary artery. Anything which obstructs the flow of blood through the pulmonary circuit, which either opposes the onward flow from the right ventricle to the lungs, or the forward flow thence to the left auricle, may produce this backward pressure. Thus, inflammation of the lungs, emphysema, tumours, and collections of fluid in the pleura, act in the former way, incompetency of the mitral valve in the latter.

From tissue-degeneration the valves of the right side of the heart may be rendered incompetent, the heart's walls weakened, and its cavities dilated. From backward pressure of blood from the lungs and from mechanical distension of the heart's cavities, the same results occur.

The exciting causes are different, but the effects are the same. In nearly every instance the cause is permanent; the effect is therefore to the same extent permanent. A shrunk tricuspid or pulmonic valve cannot be made sound; a dilated right ventricle from degenerated walls cannot be restored to its natural size. Emphysema is not curable; nor are intra-thoracic tumours removable; neither can an incompetent mitral or aortic valve be rendered competent. The only cause, then, influencing the right heart which is removable, is inflammation, congestion, or some such affection of the lungs. The only effect, therefore, upon the right heart which is curable, is that which acknowledges this cause. If, then, a patient suffering from acute bronchitis, or from double pneumonia, or from sudden effusion into the pleura, is at once found to have an incompetent tricuspid which was known not to exist before, the lesion is due to the back-flooding caused by the obstructed flow of blood through the lungs, and the incompetency will, in all probability, disappear on the subsidence of the inflammation or the removal of the effusion.

When tricuspid incompetency depends upon degeneration of the valve, it is from first to last progressive; it acknowledges no improvement; it establishes a permanent regurgitation from ventricle to auricle: it thus throws back a refluent wave of blood upon the venous system of the body, which leads to local congestions, general dropsy, and death. When, too, it supervenes upon any chronic affection of the lungs, as chronic bronchitis, asthma, emphysema, without the aid of a fresh exciting cause, its advent is marked by slight œdema of the ankles, which may always be regarded as the sure herald of approaching death. In the same light is tricuspid incompetency to be viewed when it is consecutive to mitral incompetency. Not unfrequently, however, tricuspid incompetency, arising out of mitral incompetency by reason of the obstructed flow of blood which the latter causes in the lungs, is greatly aggravated by an accession of acute bronchitis induced by cold. Dropsy, which until now had existed as a mere puffiness of the ankles only, extends to the whole subcutaneous cellular membrane; the face is bluish-red and bloated; the eyes are congested, staring, and watery; the external jugulars stand forth, full, tense, and throbbing; veins large and tortuous meander over the neck and front of the chest, and the breathing, half-laboured, half-panting, wheezes in agony of distress. Many such cases occur in the practice of every physician of experience, who will be able to confirm this fact, that proper treatment removes the exaggerated secondary consequences induced by the inflammation, and restores the patient to the same, or even to a better condition than that in which the inflammation found him. Improvement, however, continues but for a short time; a fresh accession of inflammation occurs with its attendant consequences; treatment again removes it; again does it occur, and again it is subdued by treatment; and thus, with alternations of fresh accessions and improvements, is the patient worried, until at length one such attack overwhelms him in irretrievable ruin.

The history, the nature, the reason, afford but a gloomy prospect in affections of the right side of the heart. With few, very few, exceptions, they arise and progress steadily unto death. They do not kill suddenly, because the right heart does not supply the blood necessary for the due maintenance and innervation of the nervous system, but they kill none the less certainly by the secondary effects which they produce in every organ, every tissue of the body.—*The Lancet*, Nov. 23d, 1872.

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*Treatment of Disease in Children.* By EUSTACE SMITH, M.D. Lond., Physician to His Majesty the King of the Belgians.

There is one class of remedies which is of singular value in the treatment of the diseases of young children—viz., the alkalies. In all children (in infants especially) there is constant tendency to an acid fermentation of their food. This arises partly from the nature of their diet, into which milk and farinaceous matters enter so largely; partly from the peculiar activity of their mucous glands, which pour out an alkaline secretion in such large quantities. An excess of fari-

naceous food, therefore, soon begins to ferment, and an acid is generated, which stimulates the mucous membrane to further secretion. In all chronic diseases, and in many of the acute disorders, this sour condition of the stomach and bowels is present. Alkalies are therefore useful —firstly, in neutralizing the acid products of this fermentation; and secondly, in checking the too abundant secretion from the mucous glands. A few grains of soda or potash, given an hour or two after taking food, will quickly remedy this derangement and remove the distressing symptoms which arise from it. In the chronic diseases, indeed, attention to this point is of especial importance: for by placing the stomach and bowels in a healthy state, and insuring a proper digestion of food, we put the child in a fair way of recovery, and prepare the way for the administration of tonic and strengthening medicines, by which his restoration to health is to be brought about.

In prescribing for infants, an aromatic should always be included in the mixture. The aromatics are useful, not only for their flavouring properties, but also for their value in all those cases of abdominal derangement where flatulence, pain, and spasm, resulting from vitiated secretions and undigested food, are present to increase the discomfort of the patient. Such dyspeptic phenomena are usually relieved rapidly by the use of these agents; and aniseed, cinnamon, caraway-seed, or even tincture of capsicum in minute doses, will be found important additions to the prescription in all cases where alkalies are required.

In prescribing for children, the proper dose of a medicine cannot always be calculated according to the age of the child, and does not in all cases bear the same proportion to the quantity suitable for an adult. For certain drugs children show a remarkable tolerance, while to the action of others they show as remarkable a susceptibility. Thus, opium, it is well known, acts upon a child more powerfully than would be expected, judging from the mere difference of age. It should therefore be given to infants with a certain caution, especially if the child be enfeebled by disease. It is, however, a medicine which is of especial value in the treatment of the diseases of infancy, and may be given without fear if care be taken not to repeat the dose too frequently. Belladonna, on the contrary, can be taken by children in large quantities. A child of two or three years old will bear without inconvenience a dose which in an adult might produce very uncomfortable symptoms.[1] Lobelia, again, is a remedy which is very well borne by children. Dr. Ringer has given it to "very young children" in doses of five minims every hour, and in no case has he noticed any ill effects to follow its administration. Arsenic should be given to children over five years of age in the same dose as that used to adults, and infants of a month or two old will take one drop of Fowler's solution three times a day with great benefit in cases of gastric catarrh. The influence of mercury upon young children deserves remark. It seldom in them produces stomatitis or salivation; but an excess of the drug is not therefore harmless: its influence is seen in the irritation of the alimentary canal which it so often excites, and in the profound anæmia which it induces. The anæmia which is so common a sequence of constitutional syphilis in infants is no doubt often a result of too long-continued mercurial treatment.—*Med. Times and Gaz.*, April 12, 1873.

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Clinical Lecture on the Treatment of Psoas and other large Abscesses.* Delivered at St. Thomas's Hospital, London. By JOHN SIMON, F.R.S., Surgeon to the Hospital.

In reference to several cases of large chronic abscesses under his care, Mr. Simon remarked that the only real difference between psoas and most other abscesses due to diseased bone was, that its cause was deep within the body. If the

[1] It is important to remember this in giving belladonna for its sedative effects, as in pertussis.

diseased bone could be removed, the abscess would heal; but the bodies of the vertebræ were out of reach: the surgeon could only mitigate the symptoms, and leave the rest to nature. If the disease were only caries, a cure might result, with more or less angular curvature of the spine; but if necrosis were present, there was no chance of a cure, the dead bone was not absorbed, its presence kept up a constant purulent discharge, and this led to anæmia, to albuminoid disease of the liver and kidneys, and finally to death from hectic and exhaustion.

In all these cases of chronic suppuration, the amount of constitutional and visceral damage is closely proportioned to the amount of the discharge; the amount of the discharge is proportionate to the extent of the abscess-cavity, and this depends, to a great extent, on the time it is suffered to extend. The great point in the treatment of these cases is, as far as possible, to prevent the formation of a large pus-secreting cavity. If, therefore, there be any suspicion of the existence of deep suppuration, keep a sharp look out, and open the abscess as soon as you can detect fluctuation, unless the proximity of large vessels, or of other important structures, affords strong reasons for delay.

In situations where the progress of the disease can be watched, as, for example, in abscess of the knee-joint, the difference in the result, according to whether you let out the matter early or not, is very great. If the pus be soon evacuated, there is a fair chance of saving the limb, and even of regaining some motion in the joint; but if the incision be postponed, the joint soon becomes utterly disorganized, burrowing sinuses form, and the neighbouring soft parts become deteriorated by infiltration.

There is, however, this serious difficulty in opening a psoas abscess. Perhaps it forms a large bulging tumour in the groin, yet the patient is fairly well; you cut into it, he at once becomes feverish, and in a fortnight is *in extremis;* then an ignorant person may reproach you with killing the patient. But, however well and strong the patient may appear, it is certain that this febrile condition will supervene sooner or later. It is inevitable. The longer it is postponed the worse it will be, since the cavity of the abscess will be larger. Be careful, then, always to explain to the friends of the patient, that the operation is a serious one, but that the consequence will be more serious the longer it is delayed. The severity of the consequent fever may, however, be greatly mitigated by treatment. Ten days ago, I opened a large dorsal abscess in a little girl, now under my care. I made a free incision, a very large quantity of thick pus escaped, and air was not excluded, yet the child has hitherto had no fever, and appears quite comfortable. All this time the cavity of the abscess is shrinking; and if the fever should now appear, it would be far less severe than it would have been had it occurred immediately after the operation. I owe this satisfactory state of things to the local application of cold; directly the pus was evacuated, an ice-bag was applied, and has been continued since. I have succeeded equally well in a large number of similar cases, and I can confidently recommend ice as an incomparable antiphlogistic.

Of course, if necrosed bone be present, the abscess will not entirely close; a mere sinus will, however, be left, which will not drain the patient to any considerable extent.

As I have said, I do not take extreme precautions to exclude air. At present I am inclined to reserve my judgment as to the value of the carbolic acid treatment, or at least as to the theory on which it is based; it is not yet proved that bacteria are the cause of unhealthy inflammation. Certainly air, as air, does not cause inflammation; and emptying an abscess by aspiration does not prevent the inflammatory process in its cavity. Recent experiments do, however, show that bacteria pass very readily in water, and attached to moist things; and common experience teaches us that infection is much more likely to be carried by sponges and surgical instruments that by mere air. From my own experience, I do not think that air, if only ordinarily pure and dry, is such a poison to surgical wounds as some

assert; but, whatever your theory may be, always carefully disinfect all surgical instruments, etc, with boiling water.

Finally, I must qualify my advice with a caution; remember that fluctuation is not always due to pus. Open early all acute or chronic abscesses, but never cut into collections of blood or synovia. A bruise, in ill-conditioned subjects, may be followed by extensive extravasation of blood, causing a fluctuating tumour, which, if deep in the limb, might easily be mistaken for an abscess. If these extravasations be let alone, and treated with cold applications, they disappear, though they may take a long time about it; but an incision into one is generally followed by grave constitutional symptoms. If well-marked signs of inflammation appear, you must treat the swelling as an abscess; otherwise never open one.

When you are dealing with chronic suppuration, always look out for the chronic cause. The tendency of inflammation is to subside, unless there be a stimulus of some sort present. A man was admitted here some time ago, with a deep wound in the gluteal region, caused by falling on a spike; the wound did not heal, and after some weeks, on careful examination, a piece of his trousers was detected at the bottom. So, again, there is a boy with disease of the knee-joint, in my ward, whose leg has been saved entirely by attention to position. By extension of the limb, and pushing back the femur, we have greatly reduced the inflammation; and, whereas the child was before rapidly becoming worse, he is now as rapidly mending. Always treat such displacements in young subjects early and carefully; mere dislocation of the parts will keep up irritation and suppuration, without the presence of any dead bone.—*British Medical Journal*, May 10, 1873.

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### HOSPITAL NOTES AND GLEANINGS.

*Acute Pulmonary Tuberculosis with almost Complete Absence of Pyrexia.*—J. W., a dressmaker, aged 40, single, was admitted on September 3d into University College Hospital, under the care of Sir William Jenner. She had suffered from cough in winter for several years, and for the last year or two a slight dry cough had persisted during the summer. She had always lived well, and, although never very strong, had enjoyed good health until about two months before admission, when her cough became more troublesome, the expectoration more abundant, and she began to perspire at night. She soon lost strength, and was obliged to give up work. Her father died of phthisis. On admission, the patient was much emaciated and very weak, and of well-marked tubercular build. There was some dyspnœa. On examining the chest, there was found marked dulness at the right apex with bronchial breathing and occasional coarse crackling; below there was harsh breathing with finer *râles*, except at the base posteriorly. There was deficient resonance over the whole left lung; absolute dulness at the apex, where also the breathing was almost tubular with large *râles* at the end of inspiration; below this there was bronchial breathing with moist *râles* down to the base. She rallied a little after admission, but soon began to suffer from occasional attacks of diarrhœa, lost ground slowly, and died on January 12th.

The remarkable feature of her case was her temperature. Up to December 6th it was occasionally below 98 deg., but never above 99 deg.; she had then a slight febrile attack which lasted three days, but the highest temperature was only 100 deg. Again, from December 20th to December 30th, the thermometer varied from 99 deg. to 100.6 deg.

*Necropsy*, Jan. 13th.—The lungs were everywhere firmly adherent. On section the right lung was studded with tubercles, which were far more abundant at the apex than at the base. The apex contained a few small cavities, the largest not bigger than a small bean; the tissue between solid and pigmented, containing opaque and softening tubercles. Lower down the tubercles were gray, semitransparent, and firm, evidently recent; the tissue between was crepitant, and here and there emphysematous, especially at the base; no appearance of recent pneumonia; lung-tissue everywhere tough. The left lung was small and contracted;

there was a cavity of the size of a small apple at the posterior part of the apex, more tough, solid, non-crepitating tissue than in the other, and fewer distinct gray granulations. The spleen was somewhat large and soft; it weighed nine ounces. The other organs were tolerably healthy.

In the course of the *post-mortem* examination, Sir William Jenner made the following remarks:—

The relation of pyrexia to phthisis is a point which has been hotly disputed, and probably will be for some time to come. The question whether tubercle is itself a product of inflammation, or whether the inflammation is only a secondary process, has given rise to much difference of opinion amongst pathologists; but there is another aspect of the question which is of far greater importance to us as practical physicians—viz., is fever an invariable and necessary companion of acute tuberculosis? can we ever diagnose from the presence or absence of elevation of temperature that tubercles are or are not in process of formation within the body? Some have asserted that the mere fact that a person's temperature was found, after careful observation, to keep within the normal limits, was absolute proof that the patient was not the subject of active tuberculosis. The truth of this statement has lately been questioned, and, I think, justly. It is in reference to this point that the records of cases like the present are valuable. Here is a woman who, after suffering for several years from pulmonary catarrh, becomes at last, as so often happens, the subject of acute deposition of tubercle, which carries her off in about six months. Yet during the four months she has been in hospital there has been an almost complete absence of pyrexia. Her temperature has been taken at least twice every day, and until the last month it has been uniformly below 99 deg. Only during the last four weeks has she had two febrile attacks, lasting a few days each. I must say that now I see the state of the lungs, I am myself somewhat surprised; I should scarcely have thought that such an amount of tubercle could be deposited with so little elevation of temperature. No doubt a continuance of pyrexia without evident cause is of value in leading us to watch for evidence of the presence of tubercle; but after what we have seen to-day, I do not think that any of us will be likely to rely too much on the absence of pyrexia as conclusive evidence of the absence of tuberculosis.—*Brit. Med. Journ.*, April 5, 1873.

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# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*American Medical Association.* — The twenty-fourth annual meeting of the American Medical Association was held in the city of St. Louis, on May 6th, Thomas M. Logan, M.D., of California, President, in the chair.

448 delegates were registered.

Dr. John S. Moore, of Missouri, on behalf of the medical profession of St. Louis, and Dr. J. B. Johnson, on behalf of the Committee of Arrangements, delivered addresses of welcome.

Drs. N. S. Davis, of Illinois, E. L. Howard, of Maryland, H. F. Askew, of Delaware, D. W. Yandell, of Kentucky, and J. M. Toner, of District of Columbia, were appointed by the President as the Committee on Ethics.

The President then delivered his annual address.

*May* 7. Dr. E. L. Howard, of Md., on behalf of the Committee on a plan for the better arrangement of the Sections, and for the more rigid examination of papers offered for publication, recommended amendment of the by-laws so that "the Chairmen of the several Sections shall prepare and read in the general sessions of the Association, papers on the advance and discoveries of the past year, in the branches of science included in their respective Sections; the reading of such papers not to occupy longer than forty minutes for each."

Also, that "no paper shall be read before either of the Sections the reading of which occupies more than twenty minutes. Such papers shall be referred by the Section to sub-committees specially appointed for their examination. The sub-commit-

tees shall be allowed thirty days for such examination, at the end of which time they shall forward the papers to the Committee of Publication with such recommendation as they may deem proper. The authors of such papers, however, may read abstracts before the session within the allotted twenty minutes. No member shall address the session more than once upon the same subject, nor speak longer than fifteen minutes without unanimous consent."

That article 4 of the by-laws be amended by adding "the Committee of Publication shall have full discretionary powers to omit from the published transactions, in part or in whole, any paper that may be referred to it by the Association, or either of the Sections, unless specially instructed to the contrary by vote of the Association."

That a new section (11) be added to the by-laws, as follows: "No new business, resolutions by members, etc., shall be introduced at the general sessions of the Association, except on the first and fourth days of meeting."

That the Sections be rearranged as follows:—

1. Practical Medicine, Materia Medica, and Physiology.
2. Obstetrics, and Diseases of Women and Children.
3. Surgery and Anatomy.
4. Medical Jurisprudence, Chemistry, and Psychology.
5. State Medicine and Public Hygiene.

The report and amendments were adopted.

Dr. N. S. Davis, of Illinois, moved that a committee, to be known as the Judicial Council, be appointed, consisting of twenty-one members, seven elected for one, seven for two, and seven for three years, and annually thereafter seven members shall be elected, to whom shall be referred all matters of ethics, etc. Adopted.

Dr. J. J. Woodward, U. S. A., on behalf of the Medical Staff of the Army, presented a memorial letter asking the influence of the Association in securing for the medical officers of the Army an equal footing with those of the Navy, as well as with the officers of other staff corps of the Army.

Dr. Keller, of Ky., offered the following resolutions, which were adopted:—

*Resolved*, That in the opinion of this Association the rank of the medical officers of the Army ought to be fully equal to that of the officers of any other staff corps, or of the medical corps of the Navy. That we learn with regret that this is not the case, and that we regard with grave disapproval the odious discrimination thus made against a meritorious body of officers.

*Resolved*, That we look upon the law which prohibits promotion and appointments in the medical corps of the Army as unwise and unjust, and that, in our opinion, it ought forthwith to be repealed.

*Resolved*, That a committee of five be appointed by the President, to memorialize Congress on this subject, and that each member of this Association pledges himself to use all his influence with the member of Congress from his own district in behalf of the object of these resolutions.

The President appointed as the committee Drs. Keller, of Ky.; Askew, of Del.; N. S. Davis, of Ills.; John A. Murphy, of Ohio; J. M. Toner, of the District of Columbia.

Dr. Carson, of Ohio, presented the report of the Committee on Medical Education.

Dr. L. P. Yandell, Jr., of Ky., presented the report of the Committee on Medical Literature.

Dr. John S. Moore, of Mo., Chairman of the Committee on Prize Essays, reported that only one essay had been received, and that it was not judged worthy of the prize offered.

The President appointed as delegates to the British Medical Association, Drs. Francis Gurney Smith, of Pa.; Caspar Wister, of Pa.; J. Solis Cohen, of Pa.; E. Warren, of Md.; C. L. Ives, of Conn.; Edward Montgomery, of Mo.; Fordyce Barker, of N. Y.; Ed. Seguin, of N. Y.; J. C. Hutchison, of N. Y.; Paul F. Eve, of Tenn; J. A. Alexander, of Va., and C. J. O'Hagner, of N. C.

The Treasurer reported a balance on hand of $196.74.

The reports of the Librarian and Committee on Publication were presented.

The Committee on Nominations submitted the following report, which was adopted.

Place of next meeting, Detroit, Michigan, on the first Tuesday in June, 1874.

*President*—J. M. Toner, M.D., of the District of Columbia.

*Vice-Presidents*—Wm. Young Gadbury, M.D., of Miss.; James M. Keller, M.D., of Ky.; N. C. Husted, M.D., of N. Y.; and L. F. Warner, M.D., of Mass.

*Treasurer*—Caspar Wister, M D., of Pa.

*Librarian*—Wm. Lee, M D., of D. C.

*Committee on Library*—Johnson Elliot, M.D., of D. C.

*Assistant-Secretary*—T. A. McGraw, M. D., of Michigan.

*Chairmen of Sections.*—Practice of Medicine, etc., Dr. N. S. Davis, of Illinois; Obstetrics, Dr. Theophilus Parvin, of Ind.; Surgery and Anatomy, Dr. S. D. Gross, of Penna.; Medical Jurisprudence, etc., Dr. A. N. Talley, of S. C.; State and Public Hygiene, Dr. A. N. Bell, of N. Y.

*Judicial Council.*—To serve three years: Drs. W. Brodie, of Mich.; N. S. Davis, of Ill.; E. L. Howard, of Md.; W. O. Baldwin, of Ala.; H. W. Dean, of N. Y.; J. P. Logan, of Ga. To serve two years: L. S. Joynes, of Va.; R. N. Todd, of Ind.; H. F. Askew, of Del.; J. E. Morgan, of D. C.; S. Lilly, of N. J.; S. N. Benham, of Pa.; C. W. Dunlap, of Ohio. To serve one year: J. K Bartlett, of Wis.; Powell, of Ill.; Gale, of Ky.; S. G. Moses, of Mo.; J. E. Hughes, of Iowa; S. M. Bemiss, of La., and J. R. Bronson, of Mass.

Dr. N. S. Davis, of Ill., offered the following amendments to the Constitution to be acted upon at the next meeting of the Association: to substitute for the second paragraph of Section II. the following:—

"The delegates shall receive their appointment from permanently organized State Medical Societies and such County and District Medical Societies as are recognized by representation in their respective State Societies, and from the medical department of the Army and Navy of the United States of America."

And the following substitute for the fourth paragraph:—

"Each State, County, and District Medical Society, entitled to representation, shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for each additional fraction of more than half that number. The medical staffs of the Army and Navy shall be entitled to four delegates each."

Dr. W. F. Peck, of Iowa, offered the following resolutions, which were adopted:—

In view of the fact that the reports of the Surgeon General of the United States Army, as exhibited in volumes one and two of the first part of the Medical and Surgical History of the War of the Rebellion, have received a too limited circulation by reason of an insufficient issue of the same by Congress; therefore

*Resolved*, That the President and Secretary of this Association be directed to petition Congress, at the next session, in behalf of the profession, asking that the edition recently issued be reproduced in sufficient number to permit of general distribution to the members of the profession throughout the country.

*Resolved*, That the thanks of this Association are due and are hereby tendered Congress for aiding thus far in developing and presenting to the profession the reports of the Surgeon-General, as herein specified.

*Resolved*, That the thanks of this Association are hereby tendered the officers of the United States Army who have by sacrifice and labor been instrumental in placing before the profession the valuable information contained in volumes one and two of the first part of the Medical and Surgical History of the War of the Rebellion.

Dr. Frederick Horner, Jr., of Va., offered a resolution that the American Medical Association appoint a committee of one member from each of the original thirteen States of the Union, to report to the Centennial Celebration on the medical, surgical, and biographical literature of the period of 1776, as a tribute to Joseph Warren, Benjamin Rush, Arthur Lee, General Hugh Mercer, and other noble and patriotic physicians who aided to secure American Independence. Adopted.

Dr. Davis, of Ill., introduced a resolution to provide for full and careful reports of the proceedings of the various Sections at the next annual meeting, which was adopted, and a committee of five appointed for that purpose.

*May* 8. The Committee on the Nomenclature of Diseases presented a report with a resolution adopting the report as presented at Philadelphia in 1872. Dr. Woodward, U. S. A., presented a minority report with the following resolutions appended, which were adopted :—

*Resolved*, That in the opinion of this Association it is inexpedient to adopt the nomenclature and classification presented by the majority of the Committee on Nomenclature, at the meeting in Philadelphia.

*Resolved*, That a committee of three be appointed by the President, whose duty it shall be to communicate the foregoing resolution to the proper committee of the Royal College of Physicians of London, and to negotiate for the representation of the American Medical Association in the first decennial revision of their nomenclature.

The President appointed as such committee Drs. Woodward, of the U. S. Army, Jarvis, of Mass., and Stillé, of Pa.

The following resolution, offered by Dr. Toner, of the District of Columbia, was adopted :—

*Resolved*, That in the opinion of this Association it would be an opportune occasion, at the American Centennial of 1876, for holding an International Medical Congress, to consider, and if practicable to adopt, a uniform classification and nomenclature of diseases, to be used by the profession throughout the world.

Dr. N. S. Davis, of Ill., reported on behalf of the Committee on Ethics that a sufficient number of the charges against the Pathological Society of Berks County, Pa., were sustained to justify the recommendation that the said society be not allowed a representation in this Association. The report was adopted.

The special committee appointed to consider the subject of attaching a salary to the office of Permanent Secretary, reported in favour of the existing by-law, recommending that no specified salary be attached to the office. The report was adopted.

Dr. Keller, of Ky., offered the following resolution, which was adopted :—

*Resolved*, That the sum of $500 be appropriated as an honorarium for the services of the Permanent Secretary during the present year, provided such an amount remains in the treasury after paying necessary expenses.

Dr. Bell, of New York, offered the following :—

*Resolved*, That, in the judgment of this Association, the establishment of a National Sanitary Bureau, with relations to the general government similar to those of the bureaus of agriculture and education, is highly desirable as a means of promoting sanitary science and the protection of the public health.

*Resolved*, That this Association request of the United States Educational Bureau to so extend its scope of inquiry as to include vital diseases and mortuary statistics, in relation to local meteorological and geological influences, and to disseminate the information so collected throughout the country.

The resolutions were adopted and referred to the Committee on Public Hygiene.

Dr. Davis, of Ill., on behalf of the committee appointed to devise and recommend some plan for securing a more complete report of the doings in the several sections, submitted the following resolutions, which were adopted :—

*Resolved*, That the Committee of Arrangements for each annual meeting of the Association are instructed to secure the services of a sufficient number of phonographic reporters to have one in attendance on the regular sessions of each of the Sections in the afternoon, as well as during the general morning sessions. That the reports thus obtained be printed the same evening on slips or proof-sheets in sufficient number to supply all the members of the Association in attendance, early the following morning.

The second resolution provides for the payment of the expenses thereby incurred out of the funds of the Association. The

third resolution provides for the selection and revision of the most valuable parts of the proceedings and their transmission to the Secretary for publication within twenty days after the adjournment of the Association.

On motion of Dr. R. M. Bertolet, of Pa., it was

*Resolved*, That the President appoint a committee of three, to report, at the next annual meeting, upon the progress of Otology. Drs. D. B. St. John Roosa, of N. Y., R. M. Bertolet, of Pa., and S. Sexton, of N. Y., were appointed the Committee.

Dr. E. L. Howard, of Md., presented the following resolution concerning the election of officers, which was, by the rules, laid over until the next meeting.

*Resolved*, That article 4 of the constitution be amended as follows: Strike out second clause of first paragraph and insert: "They shall be nominated by the Judicial Council, and shall be elected by vote on a general ticket.

*May* 9. Dr. A. M. Pollock, of Pa., offered the following amendments to the Constitution and By-laws, which were laid over until next meeting.

That in Art. VI. of the Constitution, line 4, the word "five" be stricken out, and the word "ten" be inserted, when it will read, "Funds may be obtained by an equal assessment of not more than ten dollars annually, on each of the delegates and permanent members."

And in the By-laws, Art. V., line 1, strike out the word "five" and insert the word "ten," when it will read, "The sum of ten dollars shall be assessed annually, upon each delegate to the sessions of the Association, as well as upon each of its permanent members, whether attending or not, for the purpose of raising a fund to defray necessary expenses."

In a short farewell address the President adjourned the Association to meet in Detroit on the first Monday in June, 1874.

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*Notes of Practice at Bellevue Hospital, New York. Chronic Synovitis of the Wrist-joint.*—Dr. Burchard, one of the staff of the 2d Surgical Division, has devised a simple apparatus for applying extension and counter-extension in these cases, which is very efficient, and productive of results satisfactory to the patient.

The indication is to entirely prevent the articular surfaces of the joint from coming in contact.

This indication is fulfilled by means of a wide palmar splint extending from the middle of the forearm to three or four inches beyond the fingers, narrowing as it passes beyond them.

At each corner of the upper end of the splint is a small slot. At the lower end of the splint is a round hole of a size proper to receive a violin-key.

The splint is then padded in such a manner as to accommodate the irregularities of the limb.

Adhesive straps are now applied to the forearm, doubling upon themselves so as to form loops, passing from below upwards.

These loops are attached to the slots in the upper corners of the splint by means of tapes. This fastens the splint at its upper extremity. A broad band of adhesive plaster is next attached to the dorsum of the hand, passes a convenient distance below the fingers, doubles upon itself, and is attached to the palmar surface of the hand.

A small piece of board is then placed in the termination of this loop, in which a hole has been pierced for the reception of a piece of catgut, which is to pass out and become fastened to the violin-key.

The broad loop is then cut through in places corresponding to the interdigital spaces, and each finger-basket strapped, leaving the loop in its connection with the ends of the fingers intact.

The violin-key can now be turned, and any amount of extension made which may be desirable.

This apparatus is easily controlled by the patient, and the relief which it affords is sufficient guarantee that its application will be faithfully adhered to.—*Med. Record*, April 15, 1873.

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*Liquor Picis Alkalinus.*—Dr. L. D. Buckley, of New York, gives the following formula for this preparation, which was originally devised by his father: ℞ Li-

quid pitch ʒij; caustic potash ʒj; water fʒv. Mix and dissolve for external use. This mixes with water in all proportions, and only moderately discolours the skin. It dries rapidly and leaves very little stickiness. He has used it in all degrees of strength, and regards it as the best preparation of tar.—*Archives of Sci. and Pract. Med.*, Feb. 1873.

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*The Wharton Trial.*—In the case of Mrs. Elizabeth G. Wharton, charged with attempt to poison Eugene Van Ness, the prosecution has entered a stay of proceedings, which is a virtual abandonment of the case.

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*Vermont Asylum for the Insane.*—Dr. Wm. H. Rockwell has resigned the superintendency of this institution, in consequence of permanent disability from fracture of the thigh. Dr. Joseph Draper, of the New Jersey State Asylum, has been appointed to fill the vacancy.

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*A New Hospital at Baltimore.*—Mr. John Hopkins, of Baltimore, recently conveyed by deed to trustees thirteen acres of land in the city of Baltimore for the erection thereon of a hospital for the relief of indigent sick and orphans, and has also donated $2,000,000 for the support and maintenance of the institution.

## FOREIGN INTELLIGENCE.

*A Foreign Body in the Blood in Relapsing Fever.*—Dr. Ponfick, of Berlin, writes to the *Irish Hospital Gazette* (April 1, 1873), that the attention of the medical circles in Berlin has recently been excited by a discovery, which is, perhaps, destined to have an important influence on our ideas in reference to the pathogenesis of relapsing fever; and, possibly, also to the nature of the so-called zymotic diseases. Dr. Obermeier, one of the physicians of the Charité, has, within the last few days, directed attention to the presence of a foreign body in the blood; and Professors Virchow, Frerichs, and Langenbeck have acknowledged and confirmed the same. Dr. Obermeier has very kindly submitted several specimens for my own examination in the Pathological Institute. The blood recently taken from patients suffering from relapsing fever was immediately brought under the microscope without any addition. On the persistent contemplation of a fixed portion of the microscopic field, peculiar filiform bodies—which are of about the same size as the finest filaments of fibrine, with a length of three red corpuscles, and with a very delicate contour—are seen to emerge in the plasma, amongst the blood-corpuscles. As long as the blood remains fresh, one observes distinct movements, which manifest themselves not only as undulatory movements in the filaments themselves, but also as a power of locomotion, which enable them to travel across the field of vision. One sees, especially, that the bodies exhibit spiral contractions, then again extend themselves, sometimes appearing, and as quickly disappearing, to the view.

Dr. Obermeier has ever failed to find these bodies in the blood of healthy persons, and also of patients suffering from other zymotic diseases. It is worthy of observation, that they are visible in the febrile stage, but are not seen in the stage of remission, and shortly before or during the crisis. On the occasion of a short communication which Dr. Obermeier made in the Medical Society of Berlin describing his discovery, Langenbeck pointed out the importance of this fact, and complimented him on the carefulness and caution displayed in abstaining from the adoption of any hypothesis in reference to the nature and the pathological relations of these bodies.

In many cases of relapsing fever pronounced icterus was observed. Then the course of the disease was unfavourably modified by the severe and intense nervous depression incidental to cholæmia, and thereby assumed an unusually asthenic character. Few of those patients who were in the prime of life died directly from the disease; but generally sank from the effects of pneumonia, which set in after the remission of the fever, and—in conjunction with the consequences of icterus—usually produced a fatal termination.

On post-mortem examination one finds

an essential difference between the cases where the patients sank during an attack, and those in which they died in the stage of remission, or during the re-convalescence. In all, the *spleen* was enlarged (in some cases even unto rupture); in the first it was of a dark-blue colour, and resistent on pressure; in the latter of a bright-red colour, and with a soft, flabby consistence. On a section of this organ, one finds a diffuse, venous congestion, attended with a general hyperplasia of the pulpa and of the follicles. In no other disease is the swelling of the Malpighian corpuscles so striking; they present a whitish-yellow colour, and occasionally an abscess-like appearance. In some cases, in addition to these diffuse changes, distinctly circumscribed portions, which resemble, as well in situation as in appearance, the different stages of embolic infarcts, are met with. They are of a round or wedge-like form, generally located immediately under the capsule; in the earliest stage dark-purple, then gradually assuming a lighter colour, even unto a pale straw. Like the infarcts, they later become necrotic, form sequestra, and may so cause perisplenitis, or even—when the process is extremely active—penetration of the capsule and subsequently peritonitis. In two cases, which came recently under my observation, death ensued by a general peritonitis from such an accident.

The *liver*, like the spleen, is always abnormally large, of a reddish-yellow colour, and firm against pressure. On section, the liver tissue is somewhat pale, and manifests the usual appearance of fatty infiltration. On the microscopical examination one finds the liver-cells more or less filled with fat, and the inter-acinous connective tissue is considerably increased. Probably, a part of these organic changes owes its origin to the abuse of alcohol, so often practised by these patients. The bilious ducts are filled with retained gall-fluid even unto the remotest ramifications. But yet the ductus choledochus is free, and the contents of the intestines have their normal colour.

The *kidneys* especially demand the attention of physicians, in that the appearances evident during life render an exact diagnosis of their condition practicable. Careful observers have lately pointed out, that the urine during an attack of relapsing fever is liable to a series of important changes; for example, fresh blood, hemorrhagic, or fibrinous cylinders, and fatty degenerated epithelium, are found separately or together in the majority of cases. On an examination, the kidneys show an enlargement in every diameter; the surface is generally pale, often variegated with hemorrhagic spots. On the section the cortical substance is swollen and somewhat cloudy-opaque, with here and there brown and red lines, indicating old and recent hemorrhages. The pyramidal portion is only slightly swollen, but presents also many converging gray streaks, often mixed with brown. A microscopical examination reveals that particular condition of the epithelium, lining the tubuli contorti, to which Virchow has given the name "parenchymatous inflammation; that is, a degeneration of the cell protoplasma, characterized by the appearance of albuminous granules, which later undergo a fatty metamorphosis. On the red or brown spots one finds red blood-corpuscles, not only free, but also inclosed in an exudative mass. The fibrinous casts are generally found in the tubuli recti of the pyramidal portion. In some rarer cases hemorrhages are observed, not only in the secretory substance, but also in the pelvis of the kidney, and even in the bladder.

Notwithstanding these extensive organic changes the patient often attains a state of convalescence. But now another serious danger threatens in the intense susceptibility of the *respiratory organs*. It is striking, that the convalescent from relapsing fever is peculiarly predisposed to affections of the respiratory tract, and naturally a patient so debilitated is rarely able to resist such a new attack. The pneumonia most generally observed is fibrinous and lobar, and takes its origin in the majority of cases in the base of the lung. In other cases there is catarrhal pneumonia, with a lobular infiltration more or less confluent. In the later periods of the disease some dangerous symptoms are apt to arise in the pharynx and

larynx in the shape of an acute congestion. Moreover, in the larynx, ulceration was observed very generally, either superficial or deep, penetrating to one of the cartilages. In one or two cases sudden death ensued from an acute œdema of the lining membrane of the aditus laryngis, a consequence of the ulceration.

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*Heart Disease from Over-exertion.*—An important discussion recently took place at the Clinical Society of London, on the consequences of the extent to which rowing and other athletic exercises are used by young men. The discussion was opened by a paper by Dr. Clifford Allbutt, an university graduate and an Alpine climber, on overstrain of the heart and aorta. He was naturally, and especially as a young physician, lenient in his view of the part played by the abuse of athletics in the causation of the cases which he had observed; but he fully explained its mechanism. In the debate which followed (fully reported in the *British Med. Journal* of March 15) Dr. Greenhow stated that he had seen a dozen cases of harm from athletic sports, and at present had under his care a case of dilated heart from Alpine climbing. He expressed his opinion that injury from athletics was not uncommon. Dr. Poore referred to the case of the celebrated hound Master McGrath. At the *post-mortem* examination, Dr. Haughton had found the heart much dilated and greatly hypertrophied. Dr. Anstie referred to the case of a Swiss young gentleman, in whom severe angina was produced by inordinate walking. He remained in a dangerous position for some time, but at length recovered. Mr. Myers (Coldstream Guards) agreed with Dr. Greenhow in thinking that it would be a great mistake to encourage the youths of our country to undergo violent exertion, by letting it be supposed that athletic exercises did not sometimes injuriously affect the heart. It would be better policy to teach moderation, and thus prevent, or at least check, many cases of incipient heart-disease, such as irritability and slight hyertrophy, with or without dilatation. He believed that this, as a result of hard training in our public schools and universities, was far more common than was generally supposed; but that it was not detected, owing to the time of life at which it occurred, and to the fact that after a few years these men led quieter lives, and did not therefore continue to overstrain their hearts. In proof of this early development of heart-disease by overstrain, Mr. Meyers stated that, after he had satisfied himself that the irritable heart of the young soldier was to a great extent induced by overstrain by tight clothing and accoutrements, he examined the pulses of men who had recently undergone hard training in the public schools and universities, with precisely the same result. The sphygmograph might be made of much use in the early diagnosis of this class of incipient heart-disease. Mr. Kesteven related the particulars of a case which had come under his notice in which cardiac disease from rowing existed. Dr. Farquharson, formerly medical officer of Rugby School, agreed with Dr. Clifford Allbutt that athletic exercises in moderation, and after due preparation, were seldom injurious. Bad consequences were only met with in persons naturally feeble, or temporarily debilitated, who undertook sudden and severe exertion without previous training. In the very few instances in which he had met with cardiac strain, while medical officer to Rugby School, the boys had usually been working hard, and had undergone excessive physical fatigue when worn out by mental labour. Assistant-Surgeon Nathan had analyzed a large number of heart cases at Haslar Hospital. Out of 850 in which he was able to determine their cause, 65 were directly due to violent exertion. Dr. John Ogle (of St. George's Hospital) said that, at the time of the discussion which some years ago occurred on the effects of continued and violent muscular exercise upon the heart, especially in connection with the observations of the late Mr. Skey, he was much impressed with the idea that the evils consequent on rowing, gymnastics, cricket, and other athletics, had been greatly exaggerated by some, and much under-estimated by others. Whilst firmly believing in the advisability and

necessity of encouraging athletics at our universities and public schools, he was of opinion that there existed evidence showing that in many cases health was injured and lives damaged and impaired, by undue exercise at the universities, etc.; though, of course, it would be as absurd as unscientific either to condemn or to support any system merely upon the strength of a limited number of cases. In all probability, severe athletic sports would not do harm in the case of those whose organs were sound and free from disposition to disease, and who were trained wisely and cautiously; but in large collections of boys and young men there must of necessity be many who spontaneously undertook, or have been induced to undertake, severe sports, and who were, naturally or from temporary causes, quite unfitted for them. Many undergraduates possessed delicate organs; and he believed that it would be prudent if at the universities and schools those who intended to row, or participate in any violent games, were obliged to obtain a certificate from some competent physician as to their being in a state to undertake such exercises, and under what conditions and restrictions (if any were requisite). Dr. Ogle had seen an oarsman at Oxford taken out of the boat casting up blood profusely. Dr. Church and others had seen hæmoptysis ensuing upon violent rowing. Dr. Ogle had lately seen a gentleman, aged forty, residing on the banks of the Thames near London, who took pupils preparatory to the universities, and who was in the habit of pulling in a four-oar with them every evening. He had a decided hypertrophy and valvular mischief of the heart, traceable solely to regular and severe overexertion. Dr. R. J. Lee said that the universities would perceive with gratification the tendency now prevailing to consider the subject of exercise with scientific attention; and he regretted that the medical profession had hitherto refrained from doing so. The enumeration of isolated cases in which injurious results had followed excessive exercise was not a scientific method of investigating the principles by which exercise was to be regulated. He had for some years been engaged in considering the subject of exercise and training with a view to correct the mistakes which were made, and to prevent those unfortunate consequences which ignorance produced. The different effects produced upon the heart and vessels by different kinds of muscular exercise might be divided into two classes: those resulting from briefly sustained but very active exertion, as in short, quick races either on foot or in a boat; and those in which the exercise was not in the same sense excessive, but was sustained for some hours, as in Alpine climbing. In the former case, the muscular contractions were so powerful as to force the blood from the veins, arrest its flow through the arteries, and so produce congestion of the heart. Those who were in the habit of rowing much in races were well aware of this fact, generally known as "losing wind," and were particularly careful to avoid it. In the case of Alpine climbing, which resembled to some extent the muscular exertion employed in those cases referred to by Dr. Allbutt, the organs of respiration were chiefly oppresssed, and the tension of the vessels was increased considerably. The right side of the heart was more often affected by such exercise.—*London Med. Record*, March 19, 1873.

[This discussion is well worthy of consideration in this country, where rowing, base-ball, cricket, and gymnastic exercises are often indulged in to the great injury of some of the participants.]

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*Ligation of the Arteria Innominata.*—Mr. E. S. O'Grady, of Mercer's Hospital (*Brit. Med. Journ.*, May 10, 1873), lately ligatured the innominate artery for an aneurism of the subclavian in a patient nearly sixty years of age. The common carotid artery was also tied, but death took place the following day, with apoplectic symptoms. No post-mortem examination was permitted.

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*Treatment of Pyelitis by the Inhalation of Oleum Pini Æthereum.*—The Vienna correspondent of the *Irish Hospital Gazette* (April 15, 1873) reports that Prof. Dittel, the well-known stricture special-

ist, has for some time past employed inhalations of oleum pini æthereum (obtained from the cones of several indigenous species of pine), with great success in cases of pyelitis. Even after the first few inhalations, the characteristic smell of violets can be detected in the urine, and at the same time the pain and constant and distressing inclination to make water cease, the amount of sediment in the urine diminishes, and soon both ease and sleep return to the patient. Inhalations are, however, only useful in cases of uncomplicated pyelitis which have not been too long neglected. In cases where there is any complication (more especially nephritis), we must proceed with the greatest caution, and only continue the inhalations so long as the inclination to make water lessens, and the absolute quantity of sediment in the urine diminishes. Should fever be set up, and should the inflammatory symptoms increase, further inhalation will only do mischief. At first the patient inhales only twice a day, for about five minutes each time; if he bears this well, and should no contra-indicating head symptoms appear, then the number of inhalations may be increased to three or four. Should he be attacked with headache or sickness of stomach, we must stop the inhalations.

The chief difference between Dr. Dittel's apparatus and others is, that in his the fluid through which the patient inspires is not warmed. This simplifies it greatly without injuring its usefulness, a great object in practice. The apparatus consists of a wash-bottle, such as is to be found in every chemical laboratory, slightly modified; in other words, a middle-sized bottle with a large body, gradually tapering to a long neck. In the stopper, which is made of India-rubber, there are two holes, through each of which runs a glass tube, one reaching nearly to the bottom of the bottle, the other to within two inches of the contained fluid. To this last tube is fastened an India-rubber pipe, and to this again a mouth-piece, modified so as to suit the patient. For the sake of cleanliness this mouth-piece is, in Dittel's clinique, made of glass. In an emergency a quill is a good substitute. If now, after from 4–6 oz. of the above-mentioned balsamic oil have been poured into the bottle and well corked down, the patient draws a deep breath through the mouth-piece, the air of the room enters through the second tube, traverses the fluid and enters the lungs impregnated with particles of the oil. The smell of violets, which may soon after be detected in the urine, gives us sufficient proof that the oil has entered the circulation, and has been excreted by the kidneys. Dr. Dittel recommends this method, which is also suited to other catarrhal affections (for instance, pulmonary emphysema) very warmly for further trial, and confirms the good results obtained by it by the enumeration of numerous cases in one of our medical periodicals.

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*Veratrum Viride in Acute Rheumatism.*—Heuser (*Allg. Med. Centralzeit.*, Jan. 1873) considers veratrum viride to be superior to any other remedy in acute rheumatism. He uses a mixture of 1 part of the tincture with 4 of rectified spirit and 5 of water. Three to five drops of this mixture are given every two hours, and the joints kept warmly rolled up. The author has also observed the best effects result from its use in pleurisy, and considers that it will supersede digitalis in pneumonia and bronchitis. He warns against the use of large doses, which impair the remedial action of the drug. Five drops of the tincture reduced the pulse rate to one-half, and produced vomiting, weakness, cold sweats, a feeling of tearing and numbness in the extremities, and muscæ volitantes.—*London Med. Record*, March 19, 1873.

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*Local Treatment of Skin and Syphilitic Diseases.*—In an article published by Dr. Gamberini in the *Giornale Italiano delle Malat. Ven.*, the author gives a list of the various cases treated in the special department of the Hospital Sant Orsola of Bologna, and makes the following remarks as regards the local treatment of the skin manifestations: "In soft ulcers, iodoform combined with glycerine was eminently successful (two drachms and a half of iodoform to one ounce of glycerine). Carbolic acid and tincture of iodine were

also highly beneficial. Depilation and parasiticidal lotion formed the treatment of the various kinds of favi." The non-syphilitic skin manifestations were attacked according to their fundamental cause: the arthritic by alkalies; the herpetic by arsenical preparations; the scrofulous by anti-scrofulous remedies; with the result of showing the excellence of Dr. Bazin's doctrines.—*The Lancet*, April 12, 1873.

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*Local Employment of Chlorate of Potash in Cancerous Sores.*—In the *Berl. Klin. Wochenschrift*, No. 6, 1873, Dr. Burow, of Königsberg, advocates the local employment of chlorate of potash in the treatment of cancerous sores. His proceeding consists in sprinkling the sore with chlorate of potash in powder or crystals, and covering the whole with a wet compress. As the crystals of chlorate of potash exert a more powerful action than the powder, and excite greater pain, Dr. Burow uses the powder first, and replaces it by the crystals when sensibility has been abated. One of the cases was a cancerous sore of the left arm, which healed completely after eight weeks' treatment. Three other cases were cancerous sores of the breast; one was lost sight of, the other two are under treatment, and healing well. The fifth case recorded was connected with a cancer which originated in the periosteum of the upper jaw and left cheekbone, and then became ulcerated; in this case healing was complete in three months.—*The Lancet*, April 12, 1873.

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*Chloral in the Treatment of Tetanus.*—Mr. Carruthers, House-Surgeon to the General Infirmary, Northampton, states (*Brit. Med. Journ.*, April 26, 1873) that he has had several cases of tetanus under his observation during the last four years, and, amongst the various remedies employed, not one has given so much relief to the patient as chloral. Calabar bean reduces the spasm when it is injected; its action, however, is only temporary. There has been one case of recovery under its use, but lately it has not acted satisfactorily. Chloral not only relaxes the spasm, but induces sleep (a powerful aid towards recovery); and during its use he has never seen trismus or dysphagia ever become severe, even in fatal cases. We may therefore safely depend, he says, upon relieving two of the most distressing symptoms, even if we do not save life, by the administration of this remedy.

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*Hydrate of Chloral in Obstetrics.*—Dr. Dujardin-Baumetz has recorded, in the last number of the *Gazette Médicale de Paris*, several cases in which the use of hydrate of chloral was remarkably successful. In the first case (primipara, protracted cephalalgia, œdema of legs and eyelids, albumen in urine) a fit of eclampsia supervened two days before the labour, and lasted ten minutes. An enema with one drachm of chloral was administered, and the patient fell asleep. On the day of the accouchement, as a precaution and to avoid a recurrence of the fit, two enemata, with one drachm of chloral in each, were administered at two hours' interval. No fit occurred, and, furthermore, the contractions were quite painless, though they were even more intense and frequent than normal. In the second case, where albumen was found in the urine, there existed the usual conditions for eclampsia. Hydrate of chloral was administered as a preventive, and no fit occurred. Lastly, in several other cases, where the patients were excitable, nervous, and weak, Dr. Dujardin-Baumetz gave chloral with the greatest benefit, in doses of from one-half to one drachm. It always had the effect of soothing the pain, and, moreover, of accelerating the process of labour. Dr. Baumetz much prefers chloral to chloroform in eclampsia, but recommends that it should be administered in sufficiently strong doses (two and even three drachms).—*The Lancet*, April 12, 1873.

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*Convulsions in an Infant due to the abuse of Alcohol in the Nurse.*—M. Vernay relates a very striking case of the mischievous consequences which may result from the abuse of wine-drinking in a nurse. A child was taken with convulsions, and during five days all sorts of means, like calomel, bromide of potassium,

the hot bath, musk, belladonna, etc., were uselessly employed. M. Vernay was eventually told that the nurse drank six to eight glasses of French wine in the day, and had some more at night. It occurred to him that the convulsions in the child might be due to the alcoholic liquid thus absorbed by the nurse. The wine was ordered to be stopped, and the convulsions ceased immediately after.—*Lancet*, April 26, 1873, from *Lyon Médicale.*

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*Ammonia in Workshops as a Preventive of Mercurial Poisoning.*—In a recent communication to the Paris Academy of Sciences, Dr. Meyer made known the excellent results which he had obtained in preventing all symptoms of mercurial poisoning in the looking-glass manufactory of St. Gobain by sprinkling the floor with ammonia. He cannot explain the preservative action of ammonia, and it was accidentally that he discovered this effect; but he states that during the five years that it has been employed at St. Gobain, not one case of poisoning has been observed among the workmen, whilst there is a marked amendment in the symptoms of those who were previously affected. About half a litre of common liquid ammonia is simply to be sprinkled on the floor of the workshop every evening after the day's work.—*Lancet*, April 26, 1873.

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*Death from Chloroform.*—At the meeting of the Société de Chirugie of April 30, M. Léon Le Fort communicated a case of death from chloroform. The subject was a man thirty years of age, apparently in very good health, who applied at the hospital on account of a fissure of the anus. M. Le Fort proposed treating it by forced dilatation, to which the patient readily agreed, but as he had just eaten, the operation was put off until the next visit. On that day chloroform was administered without anything remarkable occurring, the patient falling into a calm and peaceful sleep, the pulse and respiration being regular and normal. The dilatation having been accomplished, M. Le Fort examined the condition of the patient again, and found that he continued to sleep in a manner that caused no uneasiness. A few instants afterwards, however, his attention was forcibly attracted by stertorous breathing, and he found that the patient's face had become cyanotic, and that the pulse had disappeared. His tongue was instantly drawn forward, and the various modes of effecting artificial respiration were put into force. But these, as well as the electrical current, proved of no avail, for the patient was really dead. At the autopsy nothing worthy of note was observed, except the existence of two small pulmonary cavities, which nothing in the external appearance of the patient could lead to suspect, and which seemed to have had no effect upon his general health.

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*Cholera.*—The municipality of Berlin, alarmed at the 139 cholera cases at St. Petersburg since March, is preparing for the repulse of the disease. Meanwhile, typhus fever abounds in the North German capital.—*Lancet*, April 26, 1873.

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*Eye Hospital at Geneva.* — Baron Adolph de Rothschild has given $100,000 for the foundation and endowment of a hospital for diseases of the eye at Geneva.

—

*Prize Essays.*—For the purpose of advancing the cause of humanity under the symbol of the red cross in time of peace, Her Majesty the Empress of Germany, upon the occasion of the World's Exhibition at Vienna, has offered two prizes, in the sum of 2000 Thalers each, for the following two essays:—

No. 1, for the best manual of technical surgery in war;

No. 2, for the best treatise on the Geneva Convention;

And in addition thereto, Her Majesty has granted a like sum, both for awarding premiums to articles, to be used for sanitary purposes in the field, exhibited at Vienna, and for purchasing the same.

The undersigned Central Committee, charged with the duty of carrying out Her Majesty's designs, request all persons desirous of competing for the prizes, to observe strictly the following rules deemed essential in making the award.

*The manual referred to under No.* 1, in describing the different methods of dress-

ing wounds and applying bandages, and the surgical operations occurring in war, must concisely and briefly state the present standpoint of technical surgery in war, so as to form an indispensable companion and practical assistance for every army surgeon.

*The essay under No.* 2 must contain a history of the origin of the Geneva Convention, and a statement and examination of the results experienced in carrying it into effect, together with suggestions for its further development by additions and modifications.

The prize essays written in German, French, or English, must be sent to the undersigned Central Committee not later than the 15th of May, 1874.

They must be without signature, but distinguished by a motto and accompanied by a sealed envelope, reproducing this motto on the outside, and containing within the name and residence of the author.

On the 18th of October, 1874, the prizes will be awarded to the essays to which they shall have been adjudged by a jury composed of three members, designated severally by the Austrian Patriotic Aid Association for wounded soldiers and the widows and orphans of soldiers at Vienna, by the International Committee at Geneva, and the undersigned Central Committee.

The author will have the right to publish the essay which shall obtain the prize, but if within a period of six months from and after the date of the award, he shall not have availed himself of such right, it will revert to the undersigned Central Committee.

VON HOLLEBEN, Chairman of the Central Committee of the German Associations for the relief of wounded and sick soldiers in time of war.

BERLIN, May 1, 1873.

—

OBITUARY RECORD.—Died at Munich, on the 18th of April, Baron JUSTUS VON LIEBIG, in the seventieth year of his age.

Justus Liebig was born at Darmstadt on the 13th of May, 1803, and graduated as Doctor of Philosophy at the University of Erlangen in 1822. He then removed to Paris and prosecuted with zeal his chemical studies; and in 1824 communicated to the Institute of France the results of his researches on "Fulminic Acid and the Fulminates," which gained for him marked distinction. Through the exertions of Alexander Von Humboldt he was made in that year Professor of Chemistry at the University of Giessen, and for a quarter of a century his laboratory was the centre of attraction for aspiring chemists from every quarter of the globe. In 1837 he graduated as Doctor of Medicine at the University of Göttingen. In 1845 Liebig was raised to the rank of Baron by the Grand Duke of Hesse; and academic honours poured in upon him from every country. In 1852 he accepted the Professorship of Chemistry at Munich, which he held until his death.

Liebig perfected the method of organic analysis, and may, indeed, be regarded as one of the creators of the science of organic chemistry. The works which he published were as valuable as they are numerous.

"Fuller of honours than of years the greatest of contemporary chemists has just passed away."

—— at London on the 20th of April, of cardiac dropsy, HENRY BENCE JONES, M.D., aged 59 years.

Dr. Bence Jones graduated as Bachelor of Arts in 1836, at Trinity College, Cambridge, and proceeded to study medicine at St. George's Hospital, London. In 1841 he enjoyed the benefit of Baron Liebig's instruction at Giessen, and in 1845 he was appointed physician to St. George's Hospital. He devoted special study to pathological chemistry, and particularly to the chemistry of the urine. His contributions to the transactions of the various learned societies in England, and his independent publications are numerous, and have gained for him an enviable fame and many honourary distinctions.

In his death physiological chemistry has lost one of her most earnest and successful votaries, and the science of medicine one of her most useful and eminent cultivators.

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To accomplish this has required no little labor, and in return the Author hopes for the satisfaction derivable from a continuance of the favor with which the work has hitherto been received by the profession.

New York, *April*, 1873.

By the common consent of the American and English medical press, this work has been assigned to the highest position as a complete and compendious text-book on the most advanced condition of medical science. Notwithstanding its increased size, it has been maintained at its very moderate price, rendering it in all respects one of the cheapest works now before the profession. A few notices of former editions are subjoined.

Admirable and unequalled.—*Western Journal of Medicine*, Nov. 1869.

One of the best works of the kind for the practitioner, and the most convenient of all for the student.—*Am. Journ. Med. Sciences*, Jan. 1869.

This is in some respects the best text-book of medicine in our language, and it is highly appreciated on the other side of the Atlantic, inasmuch as the first edition was exhausted in a few months. The second edition was little more than a reprint, but the present has, as the author says, been thoroughly revised. Much valuable matter has been added, and by making the type smaller, the bulk of the volume is not much increased The weak point in many American works is pathology, but Dr Flint has taken peculiar pains on this point, greatly to the value of the book. —*London Med. Times and Gazette*, Feb. 6, 1869.

Published in 1866, this valuable book of Dr. Flint's has in two years exhausted two editions, and now we gladly announce a third. We say we gladly announce it, because we are proud of it as a national representative work of not only American, but of cosmopolitan medicine. In it the practice of medicine is young and philosophical based on reason and common sense, and as such, we hope it will be at the right hand of every practitioner of this vast continent.—*California Med. Gazette*, March, 1869.

Considering the large number of valuable works in the practice of medicine, already before the profession, the marked favor with which this has been received, necessitating a third edition in the short space of two years, indicates unmistakably that it is a work of more than ordinary excellence. A marked feature in the work, and one which particularly adapts it for the use of students as a text book, and certainly renders it none the less valuable to the busy practitioner as a work of reference, is brevity and simplicity.—*St. Louis Med. Archiv.* Feb.'69.

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**HENRY C. LEA, Philadelphia.**

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## LECTURES.

*The Relative Frequency of Disease between the Right and Left Sides of the Heart; Degeneration of the Heart; its Causes and Means of Avoidance.* By CORNELIUS BLACK, M.D. (Continued from p. 87.)

*The Treatment of the Different Forms of Heart Disease already Considered.* — The particular diseases of the heart which have already been considered may come under the care of the medical attendant at any stage of their course. When the disease is limited to the left side of the heart, the case may chance to fall under the care of a physician immediately after recovery from an attack of rheumatic endocarditis. If so, the heart's action will invariably be found to be quick, irritable, and remarkably impressible to the slightest excitant. Even under perfect repose it is quicker than natural. Under the least exciting cause, whether mental or physical, the rapidity of the heart's contractions is far greater than the cause itself could possibly produce under ordinary circumstances. There are three reasons for this rapid action of the heart. The first is, the more than ordinary quantity of uric acid yet remaining in the blood; the second, the hyper-sensibility of the endocardium produced by the inflammation through which it has recently passed; and the third, the general debility arising out of the previous attack.

The explosion of acute rheumatism in the joints and in the heart has carried off the great bulk of the uric acid, but it has

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not entirely cleansed the blood of this morbid element. Sufficient yet remains behind to act the part of an irritant to the hyper-sensitive structures of the heart, and in this way to maintain for a time an increased frequency of action of that organ. The first element of treatment in such a case is, to promote the elimination of uric acid from the blood, and to allay the inordinate sensibility of the endocardium.

To eliminate the yet remaining uric acid it must be combined with something which will render it very soluble, and direct it to the kidneys. The alkalies have this property, and of these potash forms the most soluble, and therefore the most suitable, salt. But potash must not be exhibited in combination with any element which, when liberated in the system, will act the part of an irritant. Iodine is both an excitant and an irritant, therefore iodide of potassium must not be given at this particular period of treatment. The potash salts to be used are the carbonate, bromide, citrate, acetate, tartrate, nitrate, and chlorate, together with the ordinary solution of potash. These salts ought not to be administered in large doses, but in doses of from five to ten grains two or three times a day. It is very probable that alkalies were freely administered during the acute attack. It may be that they were given in doses somewhat heroic, and that they have already achieved all that such doses are calculated to effect. By the time they have thus effected their object the body has been much attenuated, and the blood is greatly impoverished. This condition is at once recognized in the wasted tissues of the body, in the delicate pallor of the general surface as compared with the natural hue of health, in the faded colour of the lips, and in the pearly appearance of the scleroticæ. If, in this condition, the large doses of potash were continued, or, if not previously given, if they were now to be administered, the potash would act upon the fibrinoid and albuminoid constituents of the blood, effect their transformation into leucine and tyrosine, and thus deprive the tissues of their pabulum for growth. That which is intended for the nourishment of the body would be diverted from its original destination, and, as leucine and tyrosine, it would appear in the urine, instead of entering into the formation of the flesh and other structures. This fact, therefore, counsels the exhibition of small doses only of potash at this particular period.

When, from the fall of the pulse, it may be inferred that the excitability of the heart has subsided, and that the excess of uric acid has been eliminated from the blood, the time has arrived when iodide of potassium may, if necessary, be exhibited. The object sought to be obtained by its exhibition will be the absorption of inflammatory exudation which is already crippling, or which may hereafter cripple, the heart in the discharge of its natural duties.

To allay the hyper-sensibility of the endocardium, the most effective agent is *digitalis*. This, exhibited in doses of five or eight drops of the tincture three times a day, very soon reduces the frequency of the heart's action, and brings it within the ordinary range of health. It is important to effect this object, because excess of action would lead to one of two results —to exhaustion and dilatation of the heart, where the blood is so impoverished that it cannot furnish the necessary materials for growth; to hypertrophy, where those materials are in sufficient quantity to serve the ordinary purposes of nutrition.

As soon as the number of the heart's contractions has been reduced to that of health, the digitalis ought either to be discontinued, or to be given in smaller doses and at longer intervals. If, after the fall of the pulse to its natural standard, the digitalis were continued in the same dose and at the same intervals as before, sudden death might possibly occur. I have never seen death produced by this drug; but I have again and again observed headache, faintness, sickness, extreme pallor of the countenance, muscular tremor, and mental alarm follow its prolonged exhibition. Death, however, has been known to occur suddenly from its continued use. Death thus suddenly induced was formerly ascribed to the *cumulative effect* of digitalis in paralyzing

the muscular fibre of the heart; but it is now more generally referred to the very opposite condition of that fibre—to a clonic contraction of the left ventricle, which at once arrests the flow of blood to all parts of the body. Under either explanation the result is the same. The supply of blood to the brain is suddenly cut off; its vessels instantly push forward their blood into the venous capillaries; they then collapse; the patient dies. This emptying of the capillaries after the cessation of the heart's action is beautifully illustrated in the circulation of the newly-hatched fish. Fixed in a glass trough beneath the microscope, the failing energies of the heart may be watched until they entirely cease. For some thirty or forty seconds after the heart has ceased to beat, the capillaries can be seen contracting and pushing forward their blood into the veins until the tissues become perfectly colourless, and the vessels themselves can no longer be distinguished from the surrounding structures. Analogy teaches that what occurs in the fish occurs also in the human subject. Given, then, the arrest of the circulation at the left heart, the arterial capillaries will continue to contract until they have completely emptied themselves of their blood. Hence, after death from this drug, we should expect to find collapse of the arterial capillaries; distension of the venous capillaries of the general system and of the lungs; distension of both auricles, but not of both ventricles, if it is true that death begins here by clonic contraction; but if such is not the case—if death is owing to paralysis of the heart—then we should expect both ventricles also to contain more or less blood, as is invariably the case in the single ventricle of the fish when it dies by asthenia under the microscope.

I am not prepared to assert positively which of these two explanations of the mode in which digitalis kills is the correct one; but the extreme pallor of the countenance, the small feeble pulse, the faintness, the giddiness, the nausea, the sense of extreme debility, the muscular tremors, and the apprehension of mind, which occasionally supervene on the continued use of this drug, are certainly more indicative of a paralyzing tendency than of a tendency to clonic contraction.

If the view that digitalis kills by paralysis of the heart is correct, how then, it will be asked, does it regulate the action of the heart by substituting *forcible* contractions for *feeble* ones—how, in short, does it convert a feeble action of the heart into a healthy contraction? The answer is, that digitalis acts by diminishing the sensibility of the nerves of the heart; that it, in consequence, reduces the number of the heart's contractions within a given time, and that it thereby gives the heart more rest, which is equivalent to power, because by rest comes refreshment, a renewal of energy, an increased capability for the manifestation of muscular force. In organic disease of that organ requiring treatment, there is always a hyper-sensibility of its nerves, and, consequently, an increased frequency of action. Digitalis is given; this hyper-sensibility is diminished; the heart is rendered less sensible of the presence of blood in its cavities; it contracts less frequently in consequence. Continue the digitalis, and you continue to diminish the sensibility of the heart; you at length abolish its sensibility entirely; and the heart, failing in consequence to recognize the presence of blood in its chambers, ceases to contract, and the patient dies. The heart may be slept to death by digitalis, as the brain and nervous system may be slept to death by opium. I must, for these reasons, confess that the old view of the action of digitalis upon the heart, finds more favour with me than does the more recent view of its action. Hence my belief is, that when digitalis kills, it kills by paralysis of the heart, and not by exciting a contraction of the ventricles which knows no relaxation except in death.

In all affections of the endocardium of the left side of the heart arising out of inflammation, digitalis will be found a valuable remedy at some period of their course. In such cases its use is specially indicated when the heart's action is quicker than natural. This statement is made despite the doctrine which forbids the employment of digitalis where the

aortic valves are incompetent. The reason assigned for the objection to its use in this valvular lesion is, that digitalis, by deadening the sensibility of the left ventricle, might cause the latter not to take cognizance of the falling back of the blood from the aorta into its cavity sufficiently quickly to prevent itself from being overwhelmed by the reflux of blood, and the vessels of the brain from being deprived of the necessary quantity of blood to maintain the functions of the nervous system. In other words, the left ventricle might be taken by surprise, and might be overwhelmed by the falling column of blood through the aortic valves, and the supply of blood to the brain might in consequence be suddenly cut off. When the action of the heart is quicker than natural, there is no danger whatever of this occurrence from the exhibition of digitalis in this incompetent condition of the aortic valves. The safe rule to be observed, both for its employment and for its discontinuance, is to give it when the heart's action is increased in frequency, to withdraw it when that action has become natural. If it were continued after the heart's action has been reduced to its natural condition, the sensibility of the endocardium might become too much deadened to take proper cognizance of the presence of blood in the ventricle, and the evil in question might then arise. Employed, however, under the precautions which I have named, digitalis may be given in aortic valvular incompetency with as much benefit and as much safety as in any other lesion of the heart.

To aid the means already stated for reducing the increased action of the heart, the general debility caused by the acute rheumatism will require consideration in the treatment. As the power of the body is wasted by disease, the nervous system becomes more excitable, quicker to receive an impression, quicker to reflect it. The power to accomplish is not equal to the excitement to act, irritability exceeds contractility; the heart, therefore, puts on increased frequency of action to compensate for the want of power. To meet this necessity, a judicious use of tonics, good food, free ventilation, and passive exercise in the open air are required.

It will often happen to those who are accustomed to treat heart disease to be called to a case like the following: The patient, between forty and sixty years of age, suffered in early life from rheumatic endocarditis, and has now suffered for some time from mitral and tricuspid incompetency, with hypertrophy of the ventricles. Upon this condition of the heart general dropsy has supervened within the last three or four days. The skin is somewhat hot and dry; the face red or bluish-red, and bloated; the eyes are more or less injected and partially suffused with tears; the lips, tongue, and buccal membrane blue; the breathing is quickened, lifting, and wheezing, and there is cough, with, perhaps, a very scanty expectoration of frothy mucus. The heart's action is hurried, irregular, unequal, and laboured, now manifested by two or three rapid contractions, brought up by a distinct jog, followed by a pause; next by two or three rhythmical contractions, followed by a distinct intermission; then by a repetition of the quick, short, irregular contractions—jog—pause! In addition to the auscultatory signs of diseased and incompetent mitral and tricuspid valves, there are epigastric pulsation and regurgitation into the external jugulars. These veins, full, tense, and throbbing, stand forth like prominent cords; between them other veins equally tense, tortuous, and distended with black blood, wind their course, whilst a sinuous interlacement of enlarged veins overspreads the upper and front part of the chest. The appetite is poor, there is some thirst, the bowels are inactive, and the urine is scanty, high-coloured, and without sediment on cooling. A few days ago there were the physical signs of valvular disease, enlarged heart, but no dropsy. To-day there are the same signs, but with anasarca, bronchitis, and general pyrexia superadded. Now, what has produced this change, and how is the case to be treated?

The aggravation of the old-standing physical signs and the superaddition of the other symptoms are entirely the result

of cold. The surface of the body received a chill; the blood was driven inwards from the superficial vessels; the balance of the circulation between the skin and the internal organs was in consequence destroyed; the vessels of the former contained a diminished quantity, the vessels of the latter an increased quantity of blood; the function of each was either entirely or partially arrested, the skin from lack of blood ceased to perspire, the internal organs from excess of blood could no longer secrete; the *débris* of tissue-waste, the elements of secretion and excretion, were retained in the blood; by it they were borne as irritants to the heart and nervous centres; both were thereby excited; the heart was thus roused to increased energy; it answered the stimulus conveyed to it; it threw back the blood with increased force to the vessels of the skin; they in turn became distended; the skin became hot; inflammatory fever was established.

A poisoned condition of the blood is the pathological cause of all this increased disturbance. It is very probable indeed that a poisoned condition of the blood is the pathological cause of all true pyrexia and of other diseases. But what is the proper treatment of the original affection of the heart, with this bronchitis, anasarca, and pyrexia superadded? To restore the natural secretions, and to eliminate from the blood the accumulated morbid matter of the excretions. How are these objects to be obtained? By restoring the natural balance of the circulation throughout the body. This done, every secretion will go on as before; the process of excretion will be re-established; harmony of function will be restored; the bronchitis will subside; the anasarca will disappear; the pyrexia will vanish. The balance of the circulation cannot be restored without some drain from the blood, either as blood withdrawn from the vessels, or in the form of an increased secretion from one or more organs. In this particular instance, the turgid jugulars—the tossing, tumbling, laboured action of the heart—the blueness of the lips—the bloated countenance—the oppressed breathing—mutely, but nevertheless earnestly, supplicate us to bleed. The necessity is great. We must bring to the case the quickest relief. Those swollen jugulars, tense almost to bursting, invite us to take off their pressure—their excess of blood. Withdraw ten, twelve, or sixteen ounces of blood from one of them, and mark the relief which will almost instantly follow. Improve the impression thus produced by a brisk purgative of sulphate of magnesia with digitalis, antimony, and calomel. As soon as the purgative shall have produced the desired result upon the bowels, the skin will relax, the bronchial membrane will begin to secrete, the kidneys to throw off more fluid, and the heart will become more steady, more regular, and its action less frequent. But I may be told that, in giving this combination of remedies, I am violating the rule of "elegant prescribing," which says that all the remedies prescribed ought to be directed to the attainment of one object: that a purgative ought not to be given in conjunction with a diuretic—a diuretic with a diaphoretic or an expectorant. My answer to this dogma is: that experience is a better guide than theory; that experience has taught me the value of these combinations; and that, as we are as yet totally ignorant of the nature and the determining causes of many of the subtle combinations which take place in the great laboratory of life, I shall continue to prescribe these combinations of remedies upon the single authority which experience affords. Let me be effective, let me be chemical, let me be elegant in my prescribing; but, if I cannot be all, let me be effective and chemical rather than elegant.

When, by bleeding and by the use of the purgative and other agents, the urgency of the case has been relieved, small doses of digitalis with the acetate of potash or ammonia, and ipecacuanha as an expectorant, or squills as both expectorant and diuretic, together with alterative doses of blue-pill or gray powder, will generally, in ten or fourteen days, place the patient in precisely the same condition as that in which he was before he was overtaken by cold. The anasarca, bronchitis, and pyrexia will have

disappeared; but the old-standing affection of the heart will remain. For years it had apparently become no worse. At length, however, other evils have suddenly arisen; and, although they have for the moment been removed, yet to the experienced physician they denote "the beginning of the end." The patient, although relieved of the superadditions and now able to return to his usual avocations, will not long remain free. In two or three months, or it may be in a shorter time, he returns to his medical attendant, suffering as before from bronchitis, anasarca, and concomitant pyrexia. Again he is relieved by measures similar to those employed in the previous instance, and once more he returns to his accustomed employment. Again, however, does he fail to hold his ground; and once again is he compelled to resort to his physician, who continues to relieve him as before, until disease at length defies the power of remedies, and the patient, overwhelmed by accumulated miseries, sinks into the grave.—*The Lancet*, Dec. 7, 1872.

(*To be concluded.*)

## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on Bed-sores.*—By Sir James Paget, F.R.S., Lecturer on Clinical Surgery at St. Bartholomew's Hospital.—Bed-sores may be defined as the sloughing and mortification or death of a part produced by pressure. When we press on any part of our bodies for a moment, on the removal of the pressure the part is quite white, owing to the blood having been pressed out. The colour immediately returns, however. In bed-sores, the pressure is continual, the blood is driven away, nourishment ceases, and death of the part takes place. There are three different forerunners of bed-sores, (1) inflammation; the prominent parts, *e. g.*, the sacrum, posterior superior spine of the illium, the trochanters, and the ends of the spines of the vertebræ, are seen to be red. (2) They may be simply pale and white. (3) They may be purple or yellow from the extravasation of blood or bloody fluid. Sloughing follows these in the skin and subcutaneous tissue and fat. These latter die before the skin, sloughing proceeds faster in them, and so when the skin comes away, the place formerly occupied by these tissues is empty. Then the deeper parts die—muscles, bone, until sometimes the spinal cord itself is exposed. Now bed-sores occur in those who are absolutely at rest. If there is the slightest movement from one side to the other bed-sores may be averted. A man with simple fracture of the femur, previously healthy, can move himself slightly from side to side, and does so instinctively. No man with simple fracture of femur ought to rise from his bed with a bed-sore. It would be the consequence of gross neglect if he did. In the case of those whose lower limbs are paralyzed, there can be no motion whatever, and so they are liable to bed-sores.

The time when bed-sores begin to make their appearance is about fourteen days—that is, in the case of a healthy man who is absolutely unmoved. They will, of course, be accelerated by dirt, if his urine and fæces are not constantly removed. There are certain cases which are especially favourable for bed-sores: the old, especially those with fractured neck of femur, and those that are the fattest and heaviest, and most likely to become œdematous. Among ordinary persons, those that are the thinnest. When, as is commonly said, their bones are ready to start through their skin; the amount of tissues between the skin and projecting point of bone is so small that it soon, as it were, wears away, and bed-sores ensue. Those again in a state of fever, such as the lowest kinds of typhus, can scarcely by any means be saved from them. Their whole system is so poor and degenerated that sloughing takes place without any pressure at all; and you may see the ends of the nose, ears, etc., sloughing from the bad supply of blood. Continuous hectic fever is a state in which they appear, being an exception to the general class of consumptive patients, who, though they may lie in bed for months, rarely have bed-sores. They manage to move slightly and thus avert them. Pyæmia is another source, and is illustrated by a case in the

hospital: a man who was admitted with phlegmonous erysipelas of a limb and was treated for it. On account of some misconduct he was discharged; after a while he came back with pyæmia and an enormous bed-sore. His skin is very pallid and soft and does not properly discharge its functions, and there is every reason to believe that every other organ of his body is in a similar state. His lungs may be auscultated and his urine examined, and nothing at all found wrong with them, and yet I venture to state that neither the lungs or kidneys are performing their functions as they ought. A pyæmic subject, being so ill-nourished, is especially liable to bed-sores. Intense fever is also a productive agent. The man, whose thigh was amputated a short time since, had a most acute and intense attack of fever, and large bed-sores appeared. Now the fever is gone, the local disease is removed, and the bed-sores are healing very rapidly. The risk of bed-sores in the old with fractured neck of femur is chiefly in the first week, therefore treatment with a view to preventing them should commence immediately the patient takes to bed. After the first week the risk is not nearly so great. There is one peculiar class in which bed-sores rapidly appear, and that is rapid destruction with inflammation of spinal marrow. If in a fracture of the spine, a portion of the spinal cord, below the seat of fracture, be irritated and inflamed, sloughing will ensue in those parts to which the nerves given off below the irritated part proceed. And this will take place in two or three days. Sir B. Brodie mentions a case in which a large slough formed on the heel in twenty-four hours. No doubt there were other causes for this. Two or three days is the usual time. The same takes place in diseases of the spinal cord, especially in acute pyelitis. There is not so much risk of sloughing in parts deprived of nerve force as in parts whose nerve force is irritated and disturbed.

Now let us look at the means of preventing bed-sores, for nine-tenths of your care must be devoted to this; for if once they appear it is very difficult to get rid of them.

First of all, look to the bed. Good bed-making is an indispensable thing in the prevention of bed-sores. Several beds have been made especially for this purpose, of which the best is Dr. Arnott's. It consists of a chest full of water; on the top of this is a waterproof sheet, and over this an ordinary sheet on which the patient is laid. Here the patient is absolutely floating on water. The waterproof sheet is not drawn tight but adapts itself to every part of the patient. A patient might lie on this for years and never have a bed-sore. Inferior to this, but very good, is Hooper's bed. Here the waterproof on the bed is tight. They will avert bed-sores for a long time, but I should not like to say that a patient would never get a bed-sore on them. But you cannot have these everywhere; you can't take them about to everyone who may need them, and there are many cases in which they cannot be used at all, as in cases of fractured neck of femur, acute inflammation of knee-joint, and many others.

In ordinary beds the best thing is an ordinary firm mattress of horse-hair; and it must rest on boards. Cords are the worst possible things, as after 24 hours or so they give under the weight of the patient, and the most prominent parts are pressed upon. Iron gives after two or three weeks. Not so boards. It must be quite level. Under the horse-hair it is better if possible to have a spring or straw mattress. Feather-beds and the like are, of course, to be utterly condemned. If possible, have two beds, so that you may lift the patient into the other when it wants making. You thus avoid making beds under him.

The next thing is to harden the skin. The best application for this is a solution of one part of nitrous ether in three of water. If the back is frequently washed with this, bed-sores may be completely averted. There is in the hospital a man paralyzed in his lower limbs; he has been in this state for ten months. By the good nursing of the sister of his ward bed-sores have been kept away. This application of nitrous ether has been used: solution of one grain of perchloride of mercury, with two drachms of nitrous ether, and

six ounces of water, is another good thing. Whiskey is used in Scotland, as is brandy sometimes in England, but these are not so good. In Germany they use a solution of tannic acid. When the parts look as if they were going to slough, these spirit applications may be too strong, and then a solution of gutta percha in chloroform is very useful. Next we have to prevent pressure on those parts where bed-sores are likely to occur. These are the middle line of the sacrum, after that, in thin persons, the posterior superior spines of the ilium, and the sacro-iliac articulations, then the trochanters of the femur. The chief thing is a frequent change of posture. If a patient can lie in four different positions during the day bed-sores may be prevented. He may lie on his back, each side, and on his face. Of course, you couldn't make a stout person lie on his face; he would simply suffocate. This change prevents the gravitation of the blood. This may easily be seen by looking at the back of a subject in the post-mortem room. The back is quite red from this cause.

When patients lie on their backs they may be saved for a time by dividing a mattress and leaving a space of six inches between the halves. You may thus save the sacrum, which will have no pressure on it. The case before referred to was treated so, but sores came on the ilium and trochanters.

Large cushions made of amadou in the shape of a horse-shoe are very good. Isinglass plaster or felt water-pillows. Pads of cotton-wool may also be used with advantage. In speaking of the mode of curing bed-sores, already formed, let me remind you to continue your preventive treatment just as if there were none, lest they come in other parts.

During the sloughing there is nothing better than a poultice of equal parts of linseed and bread and enough charcoal to have a deodorizing effect. Carrot and turnip poultices are also deodorizing, but they are not so good as the first. The poultice is best spread on ordinary tow. When spread on linen, etc., folds are liable to form, and if the patient is on these they promote the bed-sore. When slough begins to separate the resin or other stimulating ointment should be spread on the surface of the poultice.

When the slough has separated the sore should be dressed with resin ointment or Peruvian balsam, or equal parts of these in the following manner: little bits of cotton-wool should be slightly spread with the ointment, and put into the sore until it is quite full. They thus make an equable soft surface for the sore. These are the chief local means for curing bed-sores. As regards internal treatment, don't stimulate. Let the diet be gentle but good; plenty of milk and bread; little or no meat, and a small quantity of wine.—*The Students' Journal*, May 10, 1878.

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### HOSPITAL NOTES AND GLEANINGS.

*Dislocation backwards of the Hand from the Lower Ends of the Radius and Ulna.*—It is, comparatively speaking, only in recent times that dislocation at the wrist-joint has been shown to be of rare occurrence. Until Pouteau, Dupuytren, and, still more recently, Colles exposed the fallacy, the cases of fracture at the lower end of the radius—the cases of so-called Colles' fracture—were always mistaken for dislocation of the hand backwards. The diagnostic points are well given in the notes supplied to us by Mr. H. Colgate, house-surgeon, who attended to the case.

George F——, aged forty-two, bricklayer, was admitted to University College Hospital on Sept. 4th, 1872. Whilst mounted on a ladder he was straining with both hands on a rope, when it broke, and he fell backwards about eighteen feet to the ground. In his fall he struck his back against a plank sloping up to the ladder. This somewhat broke his fall, and gave him a twist to the right, so that he fell first on to his right hand, which he stretched out to save himself. He was immediately picked up and brought to the hospital. When seen by the house-surgeon he seemed much shaken, but was quite sensible, and complained chiefly of the pain in his right wrist. This pre-

sented the following deformities: The hand was slightly flexed and pronated, the patient having no power over it, but supination could be performed to a slight extent. On the palmar surface, just above the hand, was a well-marked transverse groove, and above this a well-defined transverse ridge, running out on either side to the styloid processes of the radius and ulna, which were very prominent on either side anteriorly, and seemed to have approached the hand. On the dorsal aspect, opposite to the swelling in front, was a marked eminence, abrupt above, but below running in a straight line with the dorsum of the hand. The carpal bones forming the first row could be defined at the upper border of the dorsal swelling. Flexion was much impaired and caused much pain; extension was good; lateral movements were impeded and painful. Pain was felt over the most prominent parts of the swellings, front and back.

With the hand pronated the measurements from the external condyle to the styloid processes of the radius and ulna were the same as on the sound side, but from the external condyle to the head of the middle metacarpal bone there was half an inch shortening on the injured side. Between the styloid process of the radius and the head of the second metacarpal bone, and between the styloid process of the ulna and the head of the fifth metacarpal bone, there was also half an inch shortening on the injured side. There was a transverse wound in front of the wrist about an inch long, but not apparently very deep, also another slight abrasion in the palm.

Extension and counter-extension readily reduced the deformity, which did not return on taking off extension, and the man immediately felt relieved. All passive movements returned. No crepitus was felt. The wound was dressed antiseptically, and the forearm and hand were placed on a straight back splint with a pad over the carpus.

The man also had a bruise over the sacral region, and could not pass his water at the time. He however soon recovered, passing clear urine.

*Sept. 9th.* Visited the hospital for the first time. Wound nearly healed; wrist swelled; no discoloration; movements painful.

*14th.* Wound healed; wrist bandaged and splint left off.

*Oct. 18th.* Wrist still weak; leather gauntlet fitted.—*Lancet*, May 17, 1873.

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*Cases of Wound of the Radial Artery, followed by Aneurism; Sac laid open; both ends of Vessel twisted; Rapid Recovery.*—Two cases of this were treated by Mr. Bryant, at Guy's Hospital.

Case 1. Ann B., æt. 28, admitted September 5, 1871, having received a severe incised wound in the centre of her right forearm from falling through a skylight. Bleeding followed the accident, and pressure arrested it. On admission the next day no bleeding was present. The arm was consequently placed on a splint and kept raised. On September 10, five days after the accident, bleeding occurred; it was arrested by forcibly flexing the forearm on the arm. On the 13th an aneurism was detected in the seat of the wound. Mr. Bryant at once laid it open, and, finding the radial artery partially divided, with the orifice of the wound gaping, he divided it completely, and twisted both ends of the vessel, closing the wound. Rapid recovery followed, the woman leaving the hospital well on October 2.

Case 2. Edward M., æt. 48, carman, admitted February 20, 1872, with an aneurism of the size of a walnut one inch above the carpus in the left wrist. He stated that four months previously he ran a knife into the part, and that blood spurted out for one hour. He went to the London Hospital, where he says the vessel was tied, and the wound sewn up. Two weeks after the injury a swelling appeared on the spot, and this steadily increased. On admission a pulsatile tumour, with a very thin wall, existed in the part indicated. By pressure it could be at once emptied, and pulsation in it could be arrested by pressure upon the brachial artery. The sac seemed disposed to burst. Mr. Bryant at once laid open the sac, turned out a well-formed laminated clot the size of a walnut, and twisted both ends of the ves-

sel. After he divided it—for he found a large gaping wound in it, the vessel having clearly been punctured—a rapid recovery followed, the man leaving the hospital in two days.—*Med. Times and Gaz.*, March 22, 1873.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Mosquito Netting as a Surgical Dressing.*—In all those cases where it is desirable to keep up support and pressure, and at the same time permit the free escape of all discharges from the wound, or ulcer, or whatever it may be, the ordinary mosquito netting used for a bandage meets all the indications. Bundling dressings are avoided in this way, the parts are kept cool, the discharge goes on unrestrained, and at the same time support is maintained. If the discharge is considerable, a pad of oakum may be placed beneath the parts to secure the discharge, thus insuring perfect cleanliness. This netting serves an admirable purpose in dressing large abscesses; for instance, when compression and free discharges are to be associated.—*Med. Record*, June 15, 1872.

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*Death from Chloroform.*—The following case is reported in the *Am. Practitioner* for June, 1873:—

Chloroform was administered in a napkin to a youth aged 12, for the extraction of a tooth. Before coming under its influence he vomited. After nausea had subsided he was again slowly brought under the influence of chloroform, and complaining of the pain given by the extraction of one of the roots of the tooth, a little more of the anæsthetic was administered. Simultaneously with the extraction of the remainder of the tooth, the pulse flickered and a sudden pallor came over his face. All efforts at resuscitation were in vain. The amount of chloroform (Squibb's) used, including that which was inhaled prior to the vomiting, was about half an ounce. An autopsy does not appear to have been made.

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*Death during Anæsthesia.*—Dr. Cabot reported to the Boston Soc. for Med. Improvement (Feb. 24, 1873), a case showing what he considered the only danger in the use of ether as an anæsthetic, and a danger common to all anæsthetics.

The patient, an old man, weak, but not excessively so, had undergone an operation which lasted three-quarters of an hour. He was removed from the operating room, and the usual orders to watch him were given. Five hours afterwards he had a violent attack of dyspnœa, and died. Food was found in one of the bronchial tubes.

He also referred to a similar case which had occurred some time ago. A fat woman, while lying on her back, under ether, vomited, and some of the vomitus, getting into the trachea, killed her.—*Boston Med. and Surg. Journ.*, May 29, 1873.

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*Cholera.*—This pestilence is evidently making steady advances over this country. It appears to have been introduced into New Orleans about the latter part of May, by a German emigrant vessel, and after committing some ravages in that city, it advanced up the Mississippi, Ohio, and Tennessee Rivers, spreading to the towns on their banks. Memphis, Tenn., has suffered rather severely, the deaths from the epidemic in that city on the 22d of June numbering 55. We hear of it prevailing also at Nashville, Gallatin, and other towns in Tennessee. Advancing up the Ohio River, its prevalence is announced in Evansville, Indiana, Cincinnati, Ohio, and Wheeling, W. Va. From Memphis it appears to have also deflected eastward, still following, as usual, the main lines of travel. Then it is reported to have appeared in Washington, D. C., thus leaping from the valley of the Ohio to that of the Potomac, skipping over the intervening towns. These may hereafter suffer or escape entirely as has so often occurred in the history of this epidemic.

The epidemic appears from the reports received to be less fatal and to attack a smaller proportion of the population than at its previous visitations.

At the South it has been far more fatal, according to all the reports, to the coloured than to the white population.

*Massachusetts Medical Society.—Expulsion of the Homœopaths.*—The Massachusetts Medical Society, after a protracted investigation and patient hearing of the defendants, have expelled seven of its members for being members of an exclusive medical sect, and advertising themselves as practitioners of a special system of treatment.

We must cordially unite with the editors of our contemporary, the *Boston Medical and Surgical Journal*, in congratulating "the Society that it is in a way to be at length delivered of a source of annoyance to itself and of reproach from without."

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*Notice to Subscribers.*—The valuable little work of Dr. McCall Anderson on "Diseases of the Skin" having been completed in the Library Department of our June number, we now present to our subscribers the commencement of Dr. Wilson Fox's treatise on Diseases of the Stomach. Of this work, in less complete form, two editions were speedily exhausted in England; and the third, much enlarged by the author, was published but a few months since. As it thus contains the most recent information on a class of diseases of every-day occurrence, we cannot doubt that the selection will prove satisfactory to our readers.

## FOREIGN INTELLIGENCE.

*Treatment of Paraphimosis.*—Dr. Maubiac, in an interesting monograph on Paraphimosis lately published, arrives at the following conclusions. 1. In cases of paraphimosis not complicated with simple chancres, reduction should always be attempted, whatever may be the degree and the period of the accident. 2. Division by a long median and superior incision is only indicated in cases of paraphimosis when the tightness of the constriction coincides with shortness of the prepuce. 3. When the paraphimosis is complicated with auto-inoculable chancres, any operation with a cutting instrument must be strictly avoided. If reduction be possible, it should only be performed after the virulence of the chancres has been destroyed by energetic caustics, such as the chloride of zinc. 4. Blenorrhagia, primitive syphilitic ulcerations, simple balanoposthitis, and mucous papules, do not contra-indicate either reduction or operations with a cutting instrument. 5. If adhesions, gangrene, phlegmonous inflammation of the prepuce and sheath, phlebitis, abscesses, etc., render reduction impossible, paraphimosis must be left to its natural course—always taking care, by the aid of appropriate means, to combat the complications, to hasten the resolution of the preputial swelling, and the cicatrization of the solution of continuity produced by the strangulation. 6. In irreducible paraphimosis complicated with chancres, the treatment of the former should be delayed until the cure of the latter. 7. Paraphimosis unreduced almost always leaves behind it a subpreputial tumour, constituted by hypertrophy and chronic œdema of the lower half of the prepuce. 8. This tumour must be removed by means of an inferior demi-circumcision, to complete the superior demi-circumcision produced by the ulceration of the strangulation. 9. Complete circumcision, performed behind the glans, in irreducible paraphimosis, is only applicable to cases where the prepuce is very long. It should only be done in the phase of resolution and of the ulceration of the strangulation, and if the ulceration of the strangulation has only produced an insufficient superior demi-circumcision.—*Brit. Med. Journ.*, May 24, 1873.

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*Retro-uterine Hæmatocele.*—Dr. F. Weber (*Berlin Klin. Wochenschrift*, No. 1, 1873) concludes, from an analysis of twenty-three cases of retro-uterine hæmatocele observed by him, that the condition occurs most frequently in hard-worked young women disposed to anæmia. In six out of the twenty-three cases immoderate sexual indulgence, partly known, partly conjectured, was the exciting cause; in four the immediate cause of the disorder. The right ovary was the source of the hemorrhage in eighteen cases. The prognosis, as regards life, he considers very favourable, as none of his cases were fatal—a result which he ascribes to his method of treatment—ice-bladder, perchloride of iron internally, and avoidance of puncture. Ten cases were completely restored; in three the broken-up extrava-

sation burst through the rectum.—*Med. Times and Gaz.*, May 31, 1873.

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*Influence of various Agents on the Secretion of Bile.*—At a late meeting of the Gesellschaft der Aerzte (28th March, 1873) a paper was read by Stricker, containing an account of some experiments he had made in conjunction with Dr. Röhrig on the circumstances influencing the secretion of bile. The defects of the former methods of obtaining the secretion were pointed out, and a new method suggested by which a canula was introduced into the ductus communis choledochus; from this depended a flexible caoutchouc tube, which ended in a mouthpiece that was kept constantly at the same level in a vise, thus avoiding apparent variation due to different heights of the orifice of exit. These experiments showed that all circumstances causing hyperæmia of the bloodvessels of the liver increased the secretion of bile, whilst, on the contrary, all circumstances producing anæmia caused diminution. Thus the secretion was arrested in fasting animals, whilst it augmented after food. Water introduced into the stomach or intestines caused a slight but transient increase. The introduction of purgative medicines, as croton oil, colocynth, jalap, calomel, Epsom salts, etc., materially increased the secretion of bile. It was at once stopped by ligature of the vena portæ and vena hepatica. Ligature of the hepatic vein alone materially diminished the secretion; ligature of the aorta at the diaphragm materially diminished the secretion, but did not entirely stop it; ligature below the origin of the cœliac artery augmented it; ligature of the vena cava ascendens immediately caused stoppage of the biliary secretion. All circumstances causing contraction of the vessels diminished the amount of secretion, as, for example, irritation of an exposed nerve, division of the spinal cord just below the medulla oblongata, and injection of strychnia.—*Lancet*, May 31, 1873.

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*Medico-legal Importance of Intracranial Abscess.*—We find in the *Medical Times and Gazette* (Feb. 15, 1873) the following instructive remarks on this subject:—

"It has been well said that no injury to the head is so trivial as to be thought lightly of, while scarcely any is so severe as to be altogether despaired of. The obscurity of the lesions produced by blows or falls upon the skull, the difficulties attending the right interpretation of the symptoms which result, the variations in the length of time after an injury when these symptoms appear, and the varied secondary ill-effects which may supervene upon the earlier and more immediate ones, are features about this class of accidents only too well known to surgeons. Many persons have received fatal injuries to the head without experiencing any, or if any, only slight inconvenience for some time, but who, after ten, twenty, or fifty days, have complained of headache and feverishness, soon to become delirious and unconscious, and ultimately comatose and dead. Many have been the cases of fracture of the skull in which no symptoms indicative of so grave a lesion have shown themselves until necrosis of the bone or intracranial inflammation, or both, have declared themselves by the fatal disturbances which they excite. Nor is it necessary, in order that these later consequences should be produced, that the skull should be fractured; the detachment of a large portion of the scalp, or the separation of the dura mater from the bone, is quite sufficient injury to be followed, after some days have passed away, with inflammation or suppuration within the cranium. Most surgical authors have recorded cases of the sort, and Mr. S. Cooper has left on record one case of lacerated wound of the scalp without injury to the bone, in which the patient went on well for seventy-seven days, but was then seized suddenly with hemiplegia, and died on the ninety-ninth day after the accident from an abscess in the substance of the brain on the side opposite the injury. In fact, it would be difficult to say what is the minimum amount of injury to the bone or soft parts which may terminate in some such result, providing proper care and rest be not insured, and if the person injured be a weakly and intemperate individual. Neither would it be easy to put a limit to the time at which, after an injury to the head,

suppuration within the cranium might commence—any more than it is to say, after it has taken place, whether the pus will be found upon the side of injury or on the opposite side, between the bone and dura mater or between the membranes, in the sulci of the convolutions or within the substance of the nervous matter itself. Certain it is that several weeks may elapse ere symptoms show themselves; and this fact is one to which that great surgeon, Pott, has especially drawn attention, as being well worthy the practitioner's constant care, lest he neglect the only opportunity and means by which his patient's safety can be secured. So, too, Astley Cooper notices especially the time when inflammation of the brain or its membranes follows upon violence. He says it is often about a week—never more; but frequently it does not come on until a fortnight or three weeks after the injury, and even more time must elapse before the person is quite safe or ought to deviate from a temperate regimen; and he refers to a case where inflammation of the brain was brought on as late as four months after a blow on the head."

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*A new Substitute for Quinia.*—Among the specimens of drugs exhibited in the International Exhibition in Vienna is the *Echisees scholaris*, a plant of the natural order *Apocyneæ*. It is especially abundant at Luzon, in the province of Batangar, in the Philippine Islands; and its bark has long been used by the natives, under the name of *dita*, as a remedy in all kinds of fever. Herr Gruppe, an apothecary in Manila, has found in it an uncrystallizable very hygroscopic bitter substance, to which he has given the name of *ditaïn*. The principal Spanish physician in Manila, Dr. Miguel Zina, has given it to numerous hospital patients under his care, and has found that ditaïn is not only a perfect substitute for quinia, but that its use is not followed by the disagreeable results which often attend the use of quinia. It is given in the same doses and in the same way as quinia. In many cases, also, its activity as a tonic was well marked. The ditaïn is prepared from the bark in the same way as quinia from cinchona: 100 *grammes* of bark give 2 *grammes* of ditaïn, 0.85 *gramme* of sulphate of lime, and 10 *grammes* of a perfectly inactive extractive matter. A single tree yields a large quantity of bark without injuring its growth. It is calculated that the price of ditaïn in Europe would be about 160 *francs* per kilo (3s. 6d. to 4s. per ounce). —*Brit. Med. Journ.*, June 7, 1873.

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*Beef Tea.*—The question as to the nutritive value of extract of meat has again been discussed by Baron Liebig, in a paper in which he carefully reviews the leading objections which have been urged against it. The veteran chemist's vindication of his opinions is of considerable interest, as he there sets forth his views on this subject shortly and precisely, and endeavours to correct the misrepresentations of the doctrine which he really teaches, and which he asserts that he taught from the beginning. He wishes it to be well understood that "he never asserted that beef tea and extract of meat contained substances necessary for the formation of albumen in the blood or muscular tissue;" and "that by the addition of extract of meat to our food, we neither economize carbon for the maintenance of the temperature nor nitrogen for the sustenance of the organs of our body; and that, therefore, it cannot be called 'food in the ordinary sense,' but we thereby increase the working capabilities of the body and its capacity to resist exterior injurious influences, *i. e.*, to maintain health under unfavourable circumstances." Those constituents of the meat which are soluble in boiling water take no part in the formation and renovation of the muscular tissues, but by their effect on the nerves they exercise a most decided influence on the muscular work, wherein meat differs from all other animal and vegetable food. He therefore places extract of meat, and with it tea and coffee, under the head of "nervous food," in contradistinction to articles of "common food," which serve for the preservation of the temperature and restoration of the machine. Beef tea and extract of meat are of themselves incapable of supporting nutrition or maintaining life. Liebig, however, with justice, con-

demns the conclusions of those who, from comparative experiments on the nutritive value of fresh meat and meat-extract taken *per se*, argue that the latter is not only useless for purposes of nutrition, but positively injurious. It should be clearly understood that beef tea and extract of meat are only to be regarded in the light of auxiliaries to food, rather than independent articles of nutriment.—*London Med. Record*, April 16, 1873.

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*Glycerined Vaccine Virus.*—In an interesting communication to the *Wiener Med. Wochenschrift*, Nos. 6 and 7, Dr. Fleischmann, Physician to the Vienna General Polyklinik, gives an account of the various trials that have been made of glycerined vaccine virus since its employment was first recommended by Gehiem-Rath. Dr. Muller, of Berlin, now several years since. The general result of his investigation is highly favourable, and he thus sums up the conclusions which he has arrived at: 1st. Lymph mixed with glycerine will keep better and longer than heretofore. While his own experience has not gone beyond three months and a half, other practitioners have used it with success after seven or eight months or even after two years. 2d. As by this means the lymph can be multiplied within very broad limits, its utility, where large numbers have to be vaccinated, is very great. It dispenses with the necessity which otherwise may occur in urgent cases, of taking lymph from children whom we are uncertain about, or of taking it from revaccinated persons. 3d. As the necessary quantity of lymph is more easily obtained, it is not necessary to inquire into the condition of health of so many vaccinifers, whereby much time is saved. Suspected children also, as well as those for whom the parents object, need not be resorted to for supplies. 4th. The lymph can be sent to long distances without the same fear of the effects of weather as is felt with respect to undiluted lymph. 5th. The employment of vaccine crusts may be entirely dispensed with; Dr. Piffard, of New York, having found that on several occasions where these have been employed, contagious impetigo has complicated the vaccinia. 6th. If Bœck and Guntz's observations are confirmed—viz., that the contagion of syphilis loses its poisonous properties after remaining eight days in inclosed fluid—a further advantage attaches to the dilution of lymph with glycerine.

On the other hand, if the dilution be carried too far the number of punctures which prove successful will be diminished—say to one out of two. This, indeed, may be met by multiplying them. The maturity of the pustule also sometimes does not take place until the ninth or tenth day. Some practitioners pursue an improper practice of placing the lymph derived from various sources in the same bottle, so as to have it always ready. This evidently prevents all control over the source of the lymph, and increases any danger that may arise from accidental impurity.

Before using the lymph, care must be taken to intimately mix it by means of a hair-pencil; and for want of observing this precaution some practitioners have been disappointed, they having in fact only employed the lighter glycerine which remained at the surface. If it be desired to preserve it for future use, it is best to immediately fill capillary tubes with the fresh-mixed lymph and seal carefully with wax or sealing-wax. So secured, it will remain pure and active for a twelvemonth; but when the capillaries are badly secured, mouldiness is soon perceived.

The proportions ordered to be employed by the Prussian Government are—lymph one, glycerine two, and distilled water two parts, well mixed in a watch-glass.—*Med. Times and Gaz.*, March 29, 1873.

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*Deaths from Chloroform.*—An insane criminal (*Lancet*, May 24, 1873), aged 60, had chloroform administered prior to the introduction of a catheter. At first nothing abnormal occurred; the patient became insensible; but on the introduction of the catheter he struggled so that the inhaler was again applied. Seven minutes thereafter the pulse flickered and stopped. Restorative efforts were practised without effect.

A case of death through chloroform has

just occurred at Lille, and the man who administered it—a dentist without any sort of a degree—has been condemned for "involuntary homicide" to one month's imprisonment and a fine of twelve shillings, and about twenty pounds damages. —*Lancet*, May 17, 1873.

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*Gratuitous Medical Advice.*—Dr. Wardrop was in the habit for many years of giving advice to "poor people" at his house in Charles Street, St. James's Square, and was induced to discontinue the practice from the following circumstances: He had been called out one morning early to a patient in the neighbouring square. On returning home he saw alighting from a coroneted carriage a somewhat shabby old man, whom he recognized as one of his gratuitous morning patients. He made a detour, and returning inquired of the footman the name of his master, whom he ascertained to be the Earl of ——. When his turn came the pauper patient was ushered into the consulting-room of the great surgeon. Wardrop, in his blunt and decisive style, addressed the impostor by his name. The surprise of the latter may be conceived. Wardrop, who kept notes of all his cases, ascertained that he had been defrauded of somewhat about twenty guineas. This sum he demanded under a threat of exposure of the culprit, and was successful in obtaining it. We have heard Wardrop relate this anecdote, and describe in his graphic manner the miserable appearance that the old rogue presented. The circumstances detailed took so strong an effect upon Wardrop that he determined to discontinue a vicious system. Frauds of this description are so frequent since the establishment of proprietary special hospitals and dispensaries that surgeons in general practice, particularly in the metropolis, are robbed of a large portion of their income.—*Med. Times and Gaz.*, Dec. 21, 1872.

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*Homœopathic Pilules.*—The *Practitioner* (April, 1873) has recently analyzed some of the more commonly used homœopathic pilules of the "second dilution," purchased of two leading homœopathic pharmacists of London, with the following results:—

*Sulphate of Copper Pills.*—First sample, no copper could be detected in 100 pilules; second sample, no copper could be detected in 200 pilules. The quantity of sulphate of copper in the above pilules should have been 0.006 and 0.012 grain respectively. If even as little as 0.0001 grain of the sulphate had been present, it would have been detected.

*Corrosive Sublimate Pilules.*—It was just possible to detect mercury in 200 of the pilules. The amount was, however, less than corresponds to 0.0005 grain of corrosive sublimate, whereas 0.012 grain of this salt should have been present.

*Nux Vomica Pilules, Belladonna Pilules.*—No strychnia or atropia respectively could be detected, even when 300 pilules were employed. In the case of nux vomica, *e. g.*, 300 pilules should have contained about $\frac{1}{10000}$ grain of strychnia. Now, so small a quantity as $\frac{1}{70000}$ grain of strychnia is well known to give distinct reactions to chemical tests, but no reaction could be obtained in the present case.

So far, then, it would appear that we must place any cures following the use of pilules similar to the above to the credit of the imagination. The *Practitioner* promises to continue the subject on a future occasion, and the further results shall be laid before our readers.

—

*Imperial Gratitude.*—Sir Wm. Gull was waited upon on the 20th of May by Dr. Conneau and Dr. Baron Corvisart, who presented him, on the part of the Empress Eugénie, with a costly gold box bearing the Imperial cipher in diamonds. The box contained a pair of sleeve-links worn by the late Emperor.

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Obituary Record. — Died suddenly, June 2d, 1873, of cerebral hemorrhage, W. Tyler Smith, M.D., the eminent consulting physician-accoucheur of St. Mary's Hospital, London. Dr. S. is favourably known by his able monographs on parturition and its processes, on the pathology and treatment of leucorrhœa, and his admirable manual of obstetrics.

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## LECTURES.

*The Relative Frequency of Disease between the Right and Left Sides of the Heart; Degeneration of the Heart; its Causes and Means of Avoidance.* By CORNELIUS BLACK, M.D. (Concluded from p. 110.)

*The Treatment of the Different Forms of Heart Disease already considered.*

I HAVE said that mitral and tricuspid incompetency, with hypertrophy, may exist for years without appearing to become at all worse. During this period, however, slight disturbances are apt to arise and to threaten the establishment of the secondary consequences of regurgitation. The heart's action, from some inappreciable cause, is more abrupt and more troublesome than usual in the sensations which it excites; the feet are slightly œdematous; and the breathing, a little short, becomes sensibly shorter on exertion. The patient does not consider himself materially wrong; but he feels that the action of his heart is a little more evident to him than usual, that his breathing is somewhat shorter than it was wont to be, and that he cannot in consequence walk quite so well as formerly. In no other respect is he altered. Still, his present condition is sufficiently subjective to induce him to place himself in the hands of his medical attendant.

Now, this condition is generally soon relieved by a combination of sulphate of magnesia, digitalis, and a vegetable tonic,

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together with small doses of gray powder. The digitalis first regulates the movements of the heart, and afterwards acts the part of a diuretic; the aperient gently unloads the venous capillaries of the abdominal organs and lower extremities; and the tonic maintains the tone of the body by keeping up the appetite for food. As soon as the bowels have acted a few times, the kidneys increase—sometimes greatly—their secretion; and in a few days all puffiness of the feet, all unusual trouble of the breathing, all disturbed action of the heart, are gone. Here it is not necessary to produce a sudden and powerful impression upon the system. It is sufficient to produce the desired impression by more gentle means. This will generally be effected by doses of half a drachm of sulphate of magnesia, five drops of tincture of digitalis, half an ounce of infusion of quassia, twenty drops or minims of tincture of henbane, and an ounce of cinnamon or peppermint water, taken three or four times a day. These quantities must, of course, be either increased or diminished according to the effect produced. If two, or at the most three, liquid evacuations from the bowels be thus produced in twenty-four hours, the desired object will soon be attained. During this time the patient must be sustained by a good, plain, nourishing diet. His strength must not be allowed to go down; nor will it do so, if only two or three liquid evacuations be obtained in twenty-four hours, and food of proper kind and quantity be taken. Instead of feeling depressed by each alvine evacution, the patient will feel himself relieved; and, instead of losing strength, he will daily increase in strength from the effects of the remedies employed.

In some instances of this kind, a somewhat faded hue of the lips and a more than usual pallor of the countenance indicate deterioration of the blood in a reduction of the natural quantity of the red globules. This state is rectified by adding to the mixture already advised the sulphate of iron in half-grain doses in the first instance, and in doses of from this quantity to two grains after several liquid evacuations have been produced. To begin with iron in even one-grain doses without having first unloaded the vessels of the digestive organs is, very frequently, to produce headache, nausea, loss of appetite, thirst, and more or less excitement in the general system. Given, however, under the restrictions named, it will produce no such untoward results; and its use may then be continued until the blood has reacquired its proportionate quantity of red globules, as indicated by the return of the natural colour to the lips and of the accustomed hue to the skin.

In degeneration of the heart's structures a depressing plan of treatment must never be adopted. Medicine, diet, and regimen must have for their object to support the strength, to arrest degeneration, and to prevent sudden death. When the heart's action is too feeble, the contractile power must be increased; when too slow, it must be quickened. Small doses of strychnia, with nitric acid, are the best calculated to effect the former object; ammonia, with a bitter, the latter.

In both degenerations which have been considered, there is an excess of carbon in the blood and tissues. More oxygen is therefore required, to combine with the carbon, and to convey it beyond the precincts of the vital force. So far, then, as oxygen can be introduced into the system by more medicinal agents, it should be done. This reason counsels the exhibition of those chemical agents which have the highest combining proportion of oxygen. Nitric acid, nitrate, chlorate, and permanganate of potash, stand at the head of this group. Used in conjunction with vegetable tonics, they will effect all the good which may be expected from agents of this class. If the blood has undergone any other change, it should be ascertained in what that change consists; and the proper remedy ought, if practicable, to be applied. If there is a deficiency of red globules, iron must be given; and of the preparations of this mineral the pernitrate and the persulphate will, from their large proportion of oxygen, be the best. To insure

their toleration by the stomach they ought *at first* to be given in small doses, and always immediately after food.

The same principle which governs the exhibition of medicinal agents must be applied to the food and drinks. The food should be chiefly animal—lean meat, fish, game, poultry, eggs, cheese, with a moderate use of those productions of the vegetable kingdom which contain the greatest amount of vegetable albumen, as peas, beans, maccaroni, and gluten bread.

To the question as to the use of alcoholic drinks, the chemical views that liberate the elements of alcohol in the blood, that recombine its carbon in the form of fat, or unite it with the free oxygen of the blood to the prejudice of the due oxygenation of the tissues, need not be rigidly applied. A stimulus of this kind is necessary when the patient manifests a frequent tendency to syncope, when the heart's action is very feeble, and when the extremities are usually cold. In such a case it is better to use it in small quantity, at stated intervals, than to fly to it in an emergency only, when danger threatens. The former plan is calculated to ward off sudden death—the latter may be too late to avert that catastrophe. The proper times for the exhibition of the stimulus are the intervals between meals. Given at half distance between the times of taking food, the efficacy of the stimulus will begin to be felt when the natural stimulus of the previous meal is just passing away, and the gentle stimulation thus produced will be maintained until the time for the taking of the next meal comes round. In this way the system would never be allowed to flag, the heart's action would be maintained with regular force, and the circulation through the brain would be so effectively sustained as to lessen considerably the prospect of a fatal collapse of its vessels. In this way, too, the system would never be too greatly stimulated at once, nor would the heart be urged to efforts beyond its natural power. Two or three teaspoonfuls of brandy, an ounce of wine, or four ounces of bitter ale, will be amply sufficient at one time to effect the object in view. More than this might impart too great a stimulus—less than this would scarcely maintain the feeble efforts of a degenerated heart.

To guard against the occurrence of sudden death, it must never be forgotten that, in rising from the recumbent to the erect position, the heart is suddenly required to throw the blood against the force of gravity to the brain, A heart whose muscular fibres have undergone more or less degeneration either from the influence of defective ventilation, as in the carbonized heart, or from the cause which determines the conversion of their sarcous element into fat, may be equal, and only just equal, to effect the circulation through the distant parts of the body under the ordinary stimulus of the waking condition. In this condition the whole nervous system is fully alive to the duty which it has to perform; the innervation of the heart is in consequence as great as its degenerated structures will permit it to receive, whilst the power of that organ is, for the same reason, as effective as the particular circumstances of its disease will allow. In this state, with all the stimulus and power imparted to it by the waking condition, it is just able to carry on the circulation and to maintain life. Alter this state, reduce the innervation and power of the heart by the lethargy of sleep, and in what condition do we then find the heart? The lethargy of sleep does not vanish like a shadow from the nervous system immediately after waking. Some short time must elapse before the body can resume the full activity of life, before the nervous system can rouse itself afresh, before it can impart fresh vigour and energy to the heart. As the body lies, the heart, even in its as yet depressed condition, can readily effect the cerebral circulation, because its action is not opposed by the force of gravity. It contracts as the body rests in the recumbent posture, and the blood flows with ease and freedom to the brain. There is no ascent to be climbed, no force of gravity opposing the onward stream of blood from the left ventricle. That, however, which the heart now

accomplishes with ease is much more difficult of accomplishment when the ventricular force is opposed by that of gravity. This very condition may make all the difference between perfect safety in the recumbent posture and the greatest danger of sudden death on rising to the erect position. When, therefore, the change from one to the other is made, the body should be in its greatest vigour, the nervous system in lively activity, the heart in its fittest mood and power to act. For these reasons, a patient who has a degenerated heart ought never to rise from the recumbent position immediately on waking. Where the degeneration is considerable, there is the greatest danger in doing so. What, then, is the safeguard, what the precaution to be adopted? It is this. *The recumbent position should be continued for some time after waking; the body should either be refreshed and invigorated by the natural stimulus of food, or it should be roused by some other stimulus, before the erect position is assumed.* The observance of this precaution will save many lives, its disregard will pay the penalty of death.

The most important element, however, in the treatment of these degenerations of the heart is that of the condition of the air breathed. A full supply of oxygen must be had; an absence of carbonic acid from the air respired must be ensured. The open air and perfectly ventilated apartments are essentials for the fulfilment of these conditions. A degenerated heart is not equal to much physical exertion. Exercise on foot should be taken with caution; exercise in a carriage may be taken with more freedom. The former must never be carried to fatigue, nor the latter by long continuance to weariness. Within the strength of the patient, gestation in the open air, at proper seasons, should nevertheless be practised to the fullest extent.

To secure the necessary supply of pure air within doors, ample space and perfect ventilation are indispensable. In the present construction of our dwellings these requisites are seldom indeed to be found. The eye may have been pleased, the pocket considered, but health has scarcely received a passing thought in the question of these erections. Architecture has much to undo, much to learn, before it can satisfy the simple laws of nature. In ignorance of these laws houses are built, stately edifices erected, and no thought or care is taken to render the air within as pure as the air without. It is, nevertheless, easy to accomplish this desideratum; but blind, unyielding ignorance chains death in every room.

No system of ventilation can be perfect which does not provide for a constant inflow into our rooms of an ample supply of fresh, pure air without draught, and for an equal outflow of the air already breathed and of the carbonic acid generated by respiration and by combustion. If these provisions do not exist, carbonic acid accumulates in the air of occupied apartments, and renders it at length poisonous to life. When rooms are felt to be oppressive, hot, and stifling, the too ready practice is to throw open the windows, under the belief that complete ventilation will thus be accomplished. False reasoning! Delusive error! No sooner are the windows opened than in rushes a volume of cold air, driving the heated air and carbonic acid before it through open inner doors into other apartments, and often forcing them up the well of the staircase into chambers above, in which the carbonic acid, as it cools, descends upon any occupants therein, and passes at each inspiration into their lungs. It is an error to suppose that carbonic acid, by reason of its greater specific gravity than common air, *always* seeks the ground. It, on the contrary, is rarified by heat and ascends to the ceiling of the room, from which it gradually descends as it cools, and is thus brought to the level of the breath-draught of the occupants. When the ceiling of a room is low-pitched, with the doors closed, and gas and fire burning, the carbonic acid generated floats for a short time above the breathing-level of the occupants; but as it passes from the more heated parts of the room to those whose temperature is lower, it cools, descends, and very quickly comes within the respi-

ratory grasp. It is manifest that the true principle of ventilation must insure the escape of this poisonous air at the highest level of the room, or at least at a height which is above the breathing-level of every individual. To effect this object, the inflowing air ought to be admitted at the same level, where its increased density and velocity will enable it to drive the foul, heated air before it to the outlet, through which it will escape into the great ocean of atmosphere without. Now, the admission of fresh air at this level will be productive of another important advantage; for, as the air distributes itself and descends, it will become gradually warmed, and, when it comes into contact with the living body, it will neither produce the sensation of cold nor will it excite the sensibility of the most delicate heart or lungs.

By proper calculation as to the quantity of oxygen which will be consumed and of carbonic acid which will be generated by the respiration of a given number of persons, by gas jets, and by fire, the admission of fresh air into a room may be so regulated and proportioned that the oxygen of this included air shall not undergo any sensible diminution, and that the removal of the pre-breathed air shall be effected as rapidly as it escapes from the lungs.

An atmosphere thus changed and thus purified is an important element in the treatment of every form of heart disease. In the degenerations which I have been considering, it is especially necessary; because it offers the most efficient means of removing by its oxygen the carbon which has accumulated in the system as the consequence of defective ventilation, and of preventing, by complete oxidation, that partial conversion only of the muscular fibre of the heart which effects its transformation into fat.

Whenever there is manifested by a patient the disposition to exclude the fresh air, and to immure himself at all times in the pestiferous atmosphere of over-heated, ill-ventilated apartments, the desire must be opposed with an authority and an influence which belong only to a medical man. If the habit be allowed, the day of danger and retribution will inevitably follow.

The laws of nature are the laws of life. They are as immutable as their Great First Cause—as indestructible as matter itself. They may be violated, but not abrogated. They may be disregarded, but not defied. They punish in proportion to their violation. They protect in proportion to their observance. Infused by the Creator into His works, they control alike the animate and inanimate world. The former may challenge their power, but the latter ever offers submissive obedience. Thus it is that man disobeys their injunctions and pays the penalty of death; whilst the unconscious, soulless atom submits, and is subject only to its accustomed cycle of change.—*Lancet*, December 14, 1872.

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## CLINICS.

### HOSPITAL NOTES AND GLEANINGS.

*Intra-mural Fibrous Tumour of the Uterus; Hypodermic Injections of Ergot.*—Jane R.——, aged 28, married eight years, admitted into Queen's Hospital, Birmingham, under the care of Mr. John Clay, on July 3, 1872. Has had three children, the last four years ago. The forceps were used for the delivery, and a severe post-partum hemorrhage ensued. The infant being stillborn, nursing was not required; nevertheless, recovery from the confinement was tedious, and at one time thought somewhat doubtful. The menstrual periods since the last labour have occurred regularly, but always very profusely, the discharge being more or less mixed with coagula. Six weeks ago an unusually long and severe attack of hemorrhage occurred, from which she rallied with difficulty; and, as soon as she was able, sought admission into the hospital. She was then pale and emaciated, with great anxiety of countenance, and had all the external appearance of a person suffering from advanced malignant disease. There was, however, no pain; but the uterine discharge was profuse, of a dirty-white colour, and offensive.

On examination, the uterus was found

enlarged, and could be felt distinctly above the pubes. The os was patulous, sufficiently to admit the finger, and a firm, hard substance could be felt in the posterior wall of the uterus. There was marked fulness in the recto-vaginal culde-sac, which had all the signs of a retroflexion of the uterus. The sound on being introduced scarcely passed two inches, and did not influence the recto-vaginal fulness.

Tents and Barnes's dilators were introduced into the os and cervix uteri to facilitate the diagnosis, but produced little dilatation of these structures. The os uteri was then incised, and some additional space being thus gained for exploration, it was found that the tumour involved the fundus of the uterus, and thus precluded all idea of enucleating it which had been entertained.

Iron was administered, and a generous diet prescribed, and when her condition was somewhat improved, Mr. Clay determined to give a fair trial of hypodermic injections of ergot. Mr. Stokes Dewson, the resident dispenser, prepared a concentrated solution of ergot, three minims of which were equal to four grains of ergot, and this quantity was injected hypodermically in the hypogastric region daily. The injections caused at first great pain and redness of the skin; but after a few days the injections were well tolerated. At the end of three weeks she had severe pain in the back, headache, and other symptoms evincing that she was fully under the influence of the ergot. The menstrual periods occurred, and the injections were suspended, but there was a marked diminution of the sanguineous discharge. Upwards of a hundred injections had been given, and up to December last she had menstruated three times since the treatment was commenced, and on the last occasion the flow assumed the ordinary proportions. The uterus cannot now be felt above the pubes; the fulness in the posterior part of the uterus has sensibly diminished in size, and the os is fairly constricted. The measurement of the uterus is about the same. The leucorrheal discharge has ceased; her personal appearance has surprisingly improved, and she bears the treatment to which she has been subjected with cheerful resignation. The treatment is still continued.—*Lancet*, May 10, 1873.

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*Case of Marjolin's Warty Ulcer.*—Richard P———, aged 40, a labourer, was admitted November 25, 1872, into Dr. Stevens' Hospital, under the care of Dr. William Colles.

*History.*—When fifteen years of age he was in this hospital for a lupoid affection, which resulted in the destruction of the nasal cartilage, and great disfiguration of the face, the lower eyelid on the left side being drawn down by the contraction of the adjacent integument.

About fifteen years since he was again admitted, under Mr. Colles's care, for a severe burn of the left hand and arm. He recovered completely, had perfect motion in the limb, and no evidence remained of the injury save some unsightly cicatrices.

He continued in excellent health till about a year and a half ago, when he noticed a small, hard, kernel-like growth on the back of his left hand, between the ring and the little finger, and about an inch from the knuckles; it was accompanied by slight pain and uneasiness, but otherwise gave him little trouble. He applied to the medical officer of the district, who treated the affection with caustics of various kinds, but without apparent benefit, for after the lapse of six months the disease had spread considerably—a kind of warty growth, spreading over and engaging a considerable portion of the dorsal aspect of the hand, and attended with severe pain.

In this condition he again sought the shelter of the hospital where he had been relieved on two former occasions.

*State on Admission.*—He was greatly emaciated, slept but little, had lost his appetite, and had constant and racking pain in the limb, which was a most unsightly object. The fingers were contracted and drawn back, especially the little finger and the whole of the back of the hand, including the extensor tendons, was in a state of intense ulceration, the edges of the ulcer being raised and hard, and its surface covered with symmetrical rows of peculiar granulations which could

be separated with a probe, bleeding freely when touched, and discharging a most offensive sero-purulent matter in large quantities.

Notwithstanding the malignant aspect of the morbid surface (which presented all the appearance of epithelioma), there was no evidence whatever of glandular contamination. The limb was, however, hopelessly useless, and as the man's strength was rapidly declining, amputation was decided on. The patient having been thoroughly narcotized by means of Dr. Morgan's ether inhaler, Mr. Colles removed the forearm in its upper third by the modified circular operation.

The vessels were secured by torsion, the wound sponged with a solution of chloride of zinc, its edges brought together by carbolized catgut sutures, and the stump dressed with lint soaked in carbolized oil.

It is unnecessary to enter into the details of his convalescence; suffice it to say that he recovered without an unfavourable symptom, and left the hospital on January 11, 1873, with the wound completely healed.

Mr. Colles remarked that he believed the case to be a typical one of the warty ulcer described by Marjolin. There was a total absence of those nests of cells so characteristic of epithelioma. There was, however, extensive fatty infiltration of the bones of the carpus, metacarpus, and phalanges.

There are some features of importance in this case, viz.:—

1st. The great length of time which elapsed between the receipt of the burn and the ulceration of the cicatrix.

2d. That the lymphatic glands were not contaminated, or even sympathetically enlarged.

3d. That the disease was, in the first instance, entirely cutaneous, though subsequently the deeper structures yielded to its ravages; and that the singular fibrous granulations in parallel lines which characterize it are essentially superficial growths. To use the words of Marjolin himself, "*Ces vegetations paraissant naître du derme.*"

Dr. R. W. Smith, in his admirable treatise on this formidable affection, states that he believes it to be cancerous:—

1st. From its consisting of a new structure which is capable of converting the surrounding integument into similar tissue.

2d. From its power of contaminating the lymphatic glands, of which he quotes two instances.

3d. From its capability of returning in a distant part after the removal of the original disease.

He likewise remarks that the subsequent morbid changes are not much affected by the original lesion of the skin, as an ulcer has been found with equal frequency in the cicatrix after burns, scalds, lacerated wounds, and even floggings.—*Irish Hospital Gaz.*, July 1, 1873.

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*Hemorrhage in the Fourth Cerebral Ventricle diagnosed during life.*—This interesting case is recorded as follows in the last number of the *Gaz. Hebd. de Paris:* A man was brought into the wards of Dr. Lionville at the Hôtel Dieu. He presented symptoms of stertorous respiration; anæsthesia, with resolution of limbs; and difficulty of speech; and shortly after died in a state of collapse. On his being admitted, Dr. Lionville had noticed considerable distension of the bladder, had sounded him, examined the urine, and found 6.25 of glucose and 5 of albumen to 1000 parts of water, and he had put down the diagnosis as hemorrhage seated in the neighbourhood of the fourth ventricle, on account of polyuria, albuminuria, and glycosuria. The autopsy confirmed the diagnosis. In the protuberance below the fourth ventricle and above the calamus, which, physiologically, is the region which must be punctured for producing polyuria, albuminuria, and glycosuria, there existed a hemorrhagic spot seated on the right side.—*Lancet*, June 14, 1873.

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*Foreign Body in the Bronchus with Obscure Symptoms.*—On the morning of April 13th, a child, aged two years, was admitted into St. George's Hospital, who had just before swallowed a bit of tobacco-pipe stem. The child did not appear distressed, its voice seemed natural, and

there was no paroxysmal cough. Digital examination failed to detect any foreign body, and air entered both lungs. Next day the child's breathing was laboured, its diaphragm acting violently, and the intercostal spaces being drawn in at each inspiration; air entered both lungs freely, but everywhere the expiratory murmur was prolonged, and a peculiar thrill was present over the left lung. There was much mucous expectoration, but the colour of the child was good. On Tuesday, April 15th, Dr. Barclay examined the patient, and found the breathing sonorous, the voice natural, and both lungs filling at each inspiration. He inclined to the belief that a foreign body was present in the air passages. Mr. Pollock advocated tracheotomy should the symptoms increase, and proposed to perform it the following day unless they were modified. Late on Tuesday night, although the child's colour was good, the violent diaphragmatic inspiration was increasing, and the breathing becoming more laboured. Mr. Pick opened the trachea, passed a probe down, made every possible search, but detected no foreign body. The symptoms were not relieved by the operation. On Wednesday there was little or no difference in the child; warm applications were made to the chest, a tracheotomy tube kept in, and the surrounding air moistened with steam. Subsequently the child grew feebler, until it died on Tuesday, April 22d. The autopsy the following day revealed a piece of tobacco-pipe stem, about an inch in length, lodged in the commencement of the right bronchus, so that its upper end rested on the left side of the trachea, at a spot which was ulcerated. The lungs were in part congested and consolidated. Such an impaction fully explains the almost symmetrical respiratory sounds, and accounts for the forced inspiration, whilst it shows the possibility of a probe passing into, but not detecting a foreign body at, the bifurcation of the trachea.—*Lancet*, June 14, 1873.

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# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*Treatment of Empyema by Permanent Openings in the Chest.*—At a recent meeting of the Boston Society for Medical Observation, Dr. JOHN G. BLAKE reported (*Bost. Med. and Surg. Journ.*, June 5, 1873) four cases, illustrating the good results attending this mode of treatment of empyema; and in the discussion which followed, Dr. H. I. BOWDITCH stated that he highly approved of Dr. Blake's fearless method of operating in these cases. He thought it was wrong to allow a patient to cough up a secretion which could be allowed to escape so easily. Those cases where the matter is allowed to be expectorated are, as a rule, long and tedious. The operation, on the other hand, tends greatly to hasten convalescence, and, though his experience of incision has been small, Dr. Bowditch believed that it could be done with less danger to the patient than to allow him to continue coughing without making an opening. Dr. Bowditch would urge an incision just as we would open an abscess in the thigh. After using the aspirator on one or perhaps two occasions, in order to make sure of the existence of pus and of its tendency to reaccumulate, a free opening should be made, and no half-way measures in regard to the establishment of such openings should be adopted. In one case which he had seen, the very happiest results had followed a three-inch incision.

In cases of plurisy, there are occasional attacks of orthopnœa or dyspnœa, lasting perhaps fifteen minutes, which are followed by an interval of perfect relief. The dulness is found to extend only half-way up the chest, and the examiner thinks there is less fluid than really exists. In these cases sudden death from orthopnœa may at any moment occur, and therefore in all such cases an operation should be immediately performed by aspirator or incision.

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*Ecchymosis of the Eyeball as a Sign of Fracture of the Base of the Skull.*—In an interesting clinical lecture on this subject,

Dr. R. M. Hodges (*Bost. Med. and Surg. Journ.*, April 17, 1873), after explaining, on anatomical grounds, the cause of the diversity of the position in which a traumatic extravasation of blood from the above cause may be observed, sums up his remarks in the following generalizations:—

1. That an effusion of blood beneath the integuments of the skull, if it does not gravitate backwards, often produces an ecchymosis in the cutaneous surface of the eyelids, but never of the conjunctiva of the lids or globe.

2. That a blow directly upon the eyeball may give rise to an ecchymosis of the conjunctiva, both of the globe and lids.

3. That when fracture of the base of the skull is indicated by ecchymosis, this ecchymosis appears first beneath the conjunctiva of the globe, then beneath the palpebral conjunctiva, and only subsequently in the integument of the eyelids, if at all.

4. That when the injury has been such as to make a fracture probable, external ecchymosis of the lower lid, and less frequently of the upper lid, is a significant symptom, only when it accompanies ecchymosis of the globe, or follows it, after an interval.

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*A Caution in regard to the Unguentum Zinci Oxidi of the New U. S. Pharmacopœia.*—Formerly the unguentum benzoini which forms the base of this ointment was prepared by boiling benzoin in lard. A small quantity only of the benzoin was in this way dissolved, sufficient however to obviate the rancidity of the lard. In consequence of the objections made to the mode of preparing it, that the resulting ointment was of a dirty-white colour, and deposited a portion of the benzoin when heated, it is directed in the new Pharmacopœia that the ointment shall be made by melting the lard with the tincture of benzoin. By this process it appears that a larger portion of the benzoin is incorporated in the lard, and the zinc ointment made with it becomes hence irritating. In a case in which we had occasion recently to prescribe anew some benzoated zinc ointment, we were surprised to find that it proved highly irritating instead of soothing, as formerly. We were hence led to examine the ointment, and its appearance was so different from that previously used that we inferred the apothecary had made some mistake in its preparation, but we were informed by him that it had been prepared according to the formula of the new U. S. Pharmacopœia.

We call attention to this because the use of the officinal ointment in the instance referred to caused great suffering, and if the experience of other practitioners should be in conformity with ours it will be prudent to abandon the new formula.

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*Early Menstruation.*—Dr. R. K. Clark records (*Boston Med. and Surg. Journ.*, June 19, 1873) a case of a child aged 6 years, who soon after completing her fifth year commenced to menstruate and has continued to do so regularly every 28 days. She is not precocious in any other respect, except her form, which is that of a girl of 15 or 16. An aunt of this girl is said to have begun to menstruate regularly at the age of six years.

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*University of Pennsylvania; New Buildings.*—The foundations for the central building and one pavilion of the new Hospital of the University have been laid, and the first floor joists are in position. The building will correspond in design and the material of which it is to be built with the one lately opened for the classical and scientific departments. It will front on Spruce Street, and extend from Thirty-fourth to Thirty-sixth Street. The whole plan comprises six pavilions and a central building, a corridor 13 feet wide extending along the entire front, a distance of about 680 feet. Each pavilion will be 55 by 200 feet, and will be complete in itself. Between each two of the pavilions there will be an open court yard, 75 feet wide, laid out in walks, flower beds, etc. In the basement of the main building there will be a lecture-room to accommodate two hundred students, a general kitchen, linen and splint rooms, sewing, and dining-rooms, and a scullery. In the kitchen, the food for the hospital will be cooked, and taken thence to the pavilions by rail-

roads and dumb-waiters. Each pavilion will also have a special kitchen for the cooking of special food for the patients. On the first story there will be rooms for the superintendent and matron, and a dining-room for resident physicians. In the front there will be an apothecary's room, clerk's office, board of managers' room, etc. An iron stairway will lead from the basement to the third story, and will be lighted from a skylight. The wide corridor, connecting the pavilions, will be studded with windows, which, when opened, will practically disconnect the several buildings. On the second story of the central building there will be private rooms for patients, bath-rooms, water-closets, resident physicians' rooms, and an amphitheatre, 66 feet in diameter, with seats for 700 students. The amphitheatre will extend to the third floor, and will be lighted by a skylight. The students will enter it from the third floor, the front part of which will be fitted up with small private chambers for patients. Between the central building and the pavilions, and between the pavilions themselves, there will be large verandas, opening from each floor, and overlooking the gardens in the rear.

The pavilions will be built from the same designs, and each basement will be divided into four rooms for surgical and four for medical dispensaries. Each will also contain a large waiting room for patients, a laboratory and a space, 50 by 93 feet, for special baths. On the first floor of each pavilion there will be small wards for the accommodation of 10 or 12 patients, and a rear ward for 32 patients. Attached thereto will be bath-rooms and water-closets at each end, a kitchen and dining-room, nurse's chamber, etc. etc. Stairways of slate, six feet wide, will connect the several floors, and the pavilions will be made as nearly as possible fire-proof.

The second floor will have the same accommodations as the first, and in case of necessity the third floor may also be used. Thus each pavilion will accommodate, when completed, 84 patients, and 42 more may be put in the third story of each if necessary. The hospital will be heated with steam, but large fireplaces will be built in each ward. Patent ventilators are to be used, and every effort will be made to make the air perfectly pure at all times.

At present only the central building and one pavilion are to be built, and it is expected that they will be completed during the autumn of 1874. The central building and one pavilion will cost about $210,000, and thereafter each pavilion will cost $80,000. The pavilions will be built in lines running north and south, and the patients will therefore receive the full benefit of sunlight.

The new building for the Medical Department of the University has also been begun; it is to be completed in October, 1874, at an estimated cost of $152,000.

The new building will front on Thirty-sixth Street, between Spruce and Locust, and will have a front of 160 feet and a depth of 92 feet. The basement will be entered from the level of the surrounding ground, and will contain a working laboratory, 55 by 60 feet, an assembly-room, water-closets, etc. On the first floor there will be two large lecture-rooms, with space for apparatus, the one being used for the study of chemistry, the other of materia medica. This floor will also contain the janitor's and Dean's offices and private rooms, and above them (the ceiling of the lecture-rooms being very high) another set of chambers for the use of the professors. There will be a large stairway, supported by ornamental pillars, and lighted from a dome running from the basement to the roof. On the second floor there will be a general museum, 55 by 60 feet; Doctor Wood's museum, 30 by 33 feet; and an amphitheatre, 56 by 61 feet, with seats for six hundred students, and rooms for apparatus, etc., under the ascending seats. On this floor also there will be a library room, 31 by 47 feet, and rooms for the professors and the faculty room. On the third floor there will be a room for the study of operative surgery, 29 by 53 feet, two dissecting-rooms, one 29 by 95 feet, and the other 31 by 33 feet, also preparing rooms, a scullery, etc. The dissecting rooms and the one for the study of operative surgery will be lighted

by skylights, and the roof will be studded with ventilators.—*Public Ledger, Phila.*

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*Jefferson Medical College.*—Dr. Joseph Pancoast has resigned the chair of Anatomy in this school, which he has filled for so many years with honor to himself and to the advantage of the institution.

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*International Compliment.*—Under this caption it is announced in the *Boston Med. and Surg. Journ.* (June 5, 1873), that Dr. Acland has been elected a member of the American Philosophical Society of *New York.* It is curious that our cotemporary, usually so well informed, should not know that the American Philosophical Society has its seat in Philadelphia. Its correct title is "The American Philosophical Society, held in Philadelphia, for the Promotion of useful Knowledge;" and the date of its foundation is the 25th May, 1743.

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*Medical Department of the University of Pennsylvania.*—The United States having purchased and taken possession of the old University Hall for the erection of public buildings, and the new Medical Hall in West Philadelphia not being ready for occupation, the Trustees have secured for the use of the Medical Department during the coming winter, the commodious and convenient edifice formerly occupied by the Pennsylvania Medical College, 250 South Ninth Street. All communications should be addressed to

Robert E. Rogers, M.D.,
Dean of the Medical Faculty, University of Pennsylvania, 250 South Ninth Street, Philadelphia.

## FOREIGN INTELLIGENCE.

*Syphilitic Fever.*—M. Alfred Fournier, a sub-professor of the Faculty of Medicine, has begun a course of lectures at the Hôpital de Lourcine (the Paris Lock Hospital) on syphilis as it occurs in women (*Brit. Med. Journal*, June 14, 1873). One of his lectures deserves particular notice, as it treats of what M. Fournier designates as *fièvre syphilitique*—a subject but little known even among specialists, who are in the habit of looking upon the affection as entirely apyretic, or merely symptomatic of some disturbance in the economy more or less connected with the perturbation caused by the affection in question, and not a sequence of this latter. "Fièvre syphilitique," M. Fournier says, is a sort of essential fever of a specific character, and is intimately connected with, or the result of, the syphilitic diathesis. It presents itself in two different forms: it is sometimes purely symptomatic, and at others it assumes all the characters of an essential fever. The former is the less frequent, manifesting itself as an epiphenomenon of the syphilitic eruptions, and assuming the continued type, which, however, is of short duration. The essential form principally manifests itself on the appearance of the secondary symptoms; the nervous temperament seems to act as a predisposing cause; while, among the proximate causes, may be named the expectant or want of proper treatment; and in proof of this latter assertion, M. Fournier observed that, whenever syphilis was early and properly treated, the fever was generally *nil.* This essential fever sometimes assumes the intermittent, sometimes the continued type; it is irregular in its character, and occurs with or without paroxysms. It is, however, distinguishable from the same class of fevers of malarious origin by the following symptoms. In syphilitic intermittent fever, which is nearly of the quotidian form; the paroxysms recur at night; and it also differs from the malarious intermittent type by the absence of the cold and sweating stages, as well as by the absence of those complications generally met with in the ordinary intermittent fever; but the most characteristic feature is that the spleen remains unaffected, whether during or in the intervals of the paroxysms. The continued type of syphilitic fever is like the common continued, either of the simple or paroxysmal form. M. Fournier described also a third form of syphilitic fever, in which the symptoms are very irregular, and therefore cannot be classed with any of the above types. Sometimes the fever assumes an adynamic character, somewhat analogous to typhoid, to which M. Fournier has given

the name of "typhose syphilitique." The prognosis, however, of this latter, is not so unfavourable as the genuine typhoid, and the patients recover, first from the adynamic condition, then from the fever; but the syphilis runs its course as if nothing else had happened. Another distinguishing character of the syphilitic intermittent consists in its unamenability to the action of quinia, so efficacious in ordinary intermittent fever; and the only agent that seems to have some influence on the progress of the disease in question, is mercury, either alone, or combined with the iodide of potassium; but while its efficacy has been proved in the intermittent form of syphilitic fever, its action in the continued form is *nil*, or at least uncertain. M. Fournier administers the mercury internally, unless counterindicated by the state of the stomach or bowels, in which cases he replaces it by mercurial frictions. M. Fournier offers the above, not as a theoretical speculation, but as the result of clinical observations, taken for a series of years, and with the thermometer and sphygmograph in hand.

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*Chloral as an Application in Fetid Ulcers.*—MM. Dujardin-Beaumetz and Hirne communicated at a recent meeting of the Paris Medical Hospital Society the result of the investigations they have been making into the "Anti-Putrid and Anti-Fermentiscible Properties of Solutions of Hydrate of Chloral and their Therapeutical Applications." Their attention was first drawn to the subject by the remarkable success which attended the application of a solution of chloral diluted by 100 parts of water to a vast eschar of the buttocks which occurred during an attack of typhoid. Since then they have employed the solution in the treatment of various wounds in bad condition, and in suppuration occurring in closed cavities.

In the first part of their paper they related several experiments which they had performed in order to show that various substances which are very fermentable—as albumen, muscle, urine, milk, etc.—may have fermentation entirely prevented by placing them in solutions of chloral. Still, while it may be positively stated that chloral will prevent fermentation in a great number of substances (which for the most part contain albuminoid principles), yet there are others upon which it exerts no such effect—as, for example, so fermentable a substance as the yeast of beer. As to the minimum quantity of chloral required for the manifestation of this property, the authors find that the lactic fermentation of milk is not arrested by $\frac{1}{1000}$ of chloral, while such arrest is very evident at $\frac{1}{100}$.

With respect to the therapeutical applications, the authors observe that the action of diluted chloral on wounds of a bad nature has been known for some time, Burggraeve having indicated it as one of the best applications. In Italy it has acquired a great reputation, and Dr. Francisco reports the great benefit he has derived from its use in a concentrated form (5 parts to 20) in inveterate ulcers. The authors have also employed it in numerous cases of gangrenous wounds and wounds of a bad character, but they have in the great majority of these confined themselves to solutions of $\frac{1}{50}$ or $\frac{1}{100}$. Several of these cases are published in the *Union Médicale* (May 27 and 29); and the authors believe themselves authorized to recommend the use of chloral under these circumstances. So, also, as it prevents decomposition of the urine, it may render great service in affections of the urinary organs.—*Med. Times and Gazette*, June 7, 1873.

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*Treatment of Constipation.*—Dr. Macario, of Nice, in a communication to the *Lyon Médical*, observes that in treating constipation most practitioners confine themselves to enemata, laxatives, or more or less irritating purgatives, which in point of fact rather aggravate than cure the affection. He therefore wishes to make known what he says may be truly termed a "heroic" remedy, which he has employed during twelve years with such constant success that he cannot but regard it as infallible.

Constipation, as every one knows, may may be produced either by intestinal excitement with deficiency of secretion (nervous constipation), or in consequence

of deficient contraction of the muscular coat of the intestine. Here it is produced by atony or intestinal indolence, which bad anti-hygienic habits have induced and keep up. The prolonged contact of the feces with the rectum blunts the sensibility of the mucous and muscular tissues, and the synergical contraction of the upper portions of the large intestine either does not take place or does so in an insufficient degree, constipation being the result. In *nervous* constipation the following pill should be given: Pure sulphate of iron ten centigrammes, socotrine aloes five centigrammes, atropia from one-third to one-half of a milligramme. In the *atonic* form, for atropia one centigramme of powder of nux vomica may be substituted. By the aid of these pills regular stools may be procured, even in the subjects of obstinate constipation due to ramollissement of the brain and chronic myelitis with paraplegia. Dr. Macario gives from one to three pills immediately after dinner, the object being to produce one easy, natural, non-diarrhœic evacuation. If more than this is effected, the dose is to be diminished, one or two pills sufficing in most cases. The use of these "antistyptic" pills ought not to be continued indefinitely, a longer interval being allowed to elapse between their administration in proportion as the constipation diminishes, it being of importance to allow the organs to resume their spontaneous action without any auxiliary. If the constipation returns the pills can be again had recourse to.—*Med. Times and Gaz.*, June 21, 1873.

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*Ergot of Rye in Relation to Retention of Urine.*—In No. 23 of the *Centralblatt*, Dr. Wernich calls attention to a physiological circumstance which should be borne in mind in the administration of the ergot of rye. It has long been remarked in the autopsies of persons dying after poisoning by this substance that the bladder is so constantly found distended that this must be regarded, not as an accidental circumstance, but as due to a causal connection. The explanation, indeed, is not difficult, as the action of ergot on the sphincter of the bladder has often been resorted to in therapeutics—*e. g.*, in enuresis, incontinence of the aged, paraplegia, etc. Moreover, in a numerous series of experiments performed with ergot for other purposes, the author found in numerous instances that although the bladder was emptied before the application of ergotin, yet very soon after this had been accomplished the organ was found enormously full. It is evident, therefore, that some other factor must have come into operation besides the spasmodic action of the sphincter excited by the ergot.

However, Dr. Wernich does not attempt the explanation of the phenomenon on this occasion, confining himself to the obstetrical point of view, and in this giving a useful practical hint. He refers to two cases in which ergot had been administered on account of cessation of pain, but in which effective pains seem to have been kept off by reason of a distended bladder; and he wishes accoucheurs to bear in mind not only that the condition of the bladder should be ascertained prior to any manipulation being undertaken, but also that when secale has been administered a long time without effect they should have recourse to the catheter. It is, he says, highly probable that a large portion of the instances of the failure of ergot is not due to the bad condition of the drug, or its erroneous employment, but to the obstruction to delivery caused by the coexisting distension of the bladder.—*Med. Times and Gazette*, June 14, 1873.

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*Resina Copaibæ.*—A notice of the use of the resina copaibæ in Dr. Wilks's wards at Guy's Hospital (see number of this Journal for May, 1873, p. 71) as a substitute for the simple copaiba, where a diuretic was required, has caused numerous inquiries as to the best mode of its administration. Dr. Wilks states (*Lancet*, June 21, 1873) that Mr. Gerrard, the dispenser at the hospital, advises the following formula: "Resin of copaiba, three drachms; rectified spirit, five drachms; spirit of chloroform, one drachm; mucilage of acacia, two ounces; water to make twelve ounces." An ounce (con-

taining fifteen grains) to be taken three times a day.

Dr. Wilks takes this opportunity of saying that he has received numerous communications acknowledging the superiority of the pure resin over the oleoresin in the absence of odour, at the same time that the diuretic property remains. One patient, a medical man suffering from cardiac dropsy, and who had taken the ordinary remedies without much benefit, commenced the resin in the form of a pill, taking three pills, containing five grains of the resin in each, three times daily. Diuresis at once commenced, with a departure of all the fluid from the abdomen and legs.

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*New Antidysenteric.*—In the Vienna Exhibition are shown specimens of an "antidysenteric extract" prepared from the pods of the mangosteen (Garcinia mangostana), a well-known plant in the East Indies. The extract has been prepared by Herr Gruppe of Manilla, and has been used in a large number of cases in hospital and private practice. It is said to be a trustworthy remedy in dysentery and in chronic diarrhœa, as well as in catarrhal disorders of the uterus, bladder, and urethra, and generally in diseases for which astringents are indicated. It may be given in pills, or, especially to children, in the form of syrup.

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*Death from Methylene Ether.*—Mr. Lawson Tait reports (*Med. Times and Gaz.*, July 5, 1873) the case of S. S., aged 62, admitted to the Hospital for Women, for a large multilocular ovarian tumour. She was placed under the influence of methylene ether and took it readily and quietly; after five drachms had been administered she seemed so perfectly unconscious that in a few seconds the operation would have been begun. Suddenly she seemed to be coming out of the anæsthesia, the urine passed out of her bladder, and the eyes opened. Mr. Tait noticed the pupils to be extremely dilated, and the pulse suddenly ceased. Some efforts at respiration were made, and a spasmodic effort as if the patient was about to vomit. Respiration then ceasing, it was carried on by Sylvester's method. Strong ammonia was applied under the nostrils, and a strong stimulant enema given. Other means, as rubbing the chest with a brush, dashing cold water over it, etc., were tried unavailingly. It was evident to the acting staff, who were all present, that failure of the heart was the initial part of the process of death.

The post-mortem examination was made within twenty-four hours, and revealed nothing to account for death.

—

*Case of Ichthyosis.*—Dr. E. Mapother, of St. Vincent's Hospital, Dublin, has at present under his care an instance of the above rare disease. The patient is a woman, aged 42, who first noticed the affection about two years ago. The forearms and front of the thighs and legs are the parts affected, the color resembling the upper surface of the turbot, and divided in quadrilateral masses; the cuticle can be removed in plates about two lines in thickness, leaving a raw abraded surface exposed. There is abnormal dulness of the cardiac region, owing evidently to hypertrophy of the heart, arising from the checking of secretion and irregularity of circulation in the cutaneous vessels. The disease is, of course, incurable; but Dr. Mapother's patient has obtained relief by using daily tepid baths containing six ounces of washing soda, and inunction with equal parts of glycerine and cod-liver oil.—*Brit. Med. Journ.*, June 21, 1873.

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*The Temperature in Epilepsy and Hysteria.*—Dr. Bourneville states (*Le Mouvement Médical*, No. 11) that he has satisfied himself, from observations taken in the Salpêtrière and St. Louis Hospitals, that during an attack of epilepsy the temperature augments; so also in attacks of epileptiform hysteria the temperature rises; on the contrary, in attacks of pure hysteria there does not appear to be any increase. He thinks that by this means it is possible to discover an attack of true from feigned epilepsy. Where epilepsy is simulated, the attacks are always the most severe possible, yet the temperature does not rise above the physiological degree; but when the real

attacks are severe, the temperature not only rises during the fit, but remains above the normal for several hours.—*The Practitioner*, July, 1873.

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*Wet-nursing.*—The average mortality of infants one year old throughout France is 18 per 1000. In the ten departments which chiefly receive *les petits Parisiens*, the infants whom fashion and morality in France consign to rural wet-nurses, the mortality is 51.68 per 100. In the department of la Creuse, where the people marry early and mothers nurse their own children, the mortality is 12 per cent.; in that department (spite much emigration) the births exceed the deaths; in all the others the deaths exceed the births; and a gradual depopulation is proceeding in France which excites the liveliest apprehension of the government.—*Brit. Med. Journal*, May 17, 1873.

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*Cost of an Epidemic.*—The *London Medical Record* (April 16, 1873) states that the late smallpox epidemic cost Dublin at least 35,000*l.*

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*Hospital Sunday.*—The *Lancet* for June 21 contains the following paragraph:—

"The brilliant success of the Hospital Sunday amongst ourselves has led us to think of its applicability to the United States. There can be little doubt that there it would be even more successful than here. We give our friends across the Atlantic the idea for what it is worth; they are better judges than we can be. But having regard to the American character, its liberality and its openness to appeals from the pulpit in behalf of any really worthy object, we can imagine no objection to a Hospital Sunday for the United States. Perhaps, indeed, as we have said, they might surpass us in their success. The rate of wages there, too, may make hospitals and dispensaries less necessary to a large number of the population than with us. But still, as medical men, we know that there are great hospitals in America in which good medical work is done, and, despite the wealth of the States, there must be a great number of "strangers within the gates," and others, to whom the hospitals are a great boon; and if there is any serious difficulty in meeting their expenses a Hospital Sunday would doubtless remove it in a very splendid way."

We cordially commend the above to the earnest consideration of the authorities of the congregations of every sect, and urge them to give life upon our own soil to this grandly benevolent movement. The existence in our large cities of sectarian hospitals would, probably, be urged as a reason for the sects supporting them not joining in the general movement, but, as every hospital should participate in the fund according to its annual expenditure, after deducting the income derived from endowments and legacies, this objection ought not to prove a barrier to the general adoption of a Hospital Sunday.

Hospital Sunday (June 15th) in London has just netted over 130,000 dollars, and in Birmingham, Manchester, and Liverpool, proportionately large sums. Our hospitals are greatly in need of money to maintain and extend their usefulness to the unfortunate poor, and we cannot conceive of a more effective way of supplying them with the sinews of usefulness than by a direct appeal to the instinctive charity of the people through a Hospital Sunday, and we hope that ere long we may hear of a collection being taken up for this noble object in every place of worship and in every workshop throughout the country.

—

Obituary Record.—Died, at Berlin, on the 16th of June, Moritz Romberg, aged 77. Prof. Romberg was born in Meiningen, and graduated at the University of Berlin in 1817. In 1838 he was appointed an extra-ordinary professor, and in 1845 ordinary professor, in the University of Berlin. His famous work on "Diseases of the Human System" was published in 1840–1846, and was translated into English. He was also the author of treatises on cholera, on respiratory paralysis, and of various contributions to periodicals. For some years before his death he suffered from heart disease, and to which he finally succumbed.

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To accomplish this has required no little labor, and in return the Author hopes for the satisfaction derivable from a continuance of the favor with which the work has hitherto been received by the profession.

New York, *April*, 1873.

By the common consent of the American and English medical press, this work has been assigned to the highest position as a complete and compendious text-book on the most advanced condition of medical science. Notwithstanding its increased size, it has been maintained at its very moderate price, rendering it in all respects one of the cheapest works now before the profession.

No words that we could add would increase the favor with which it has hitherto been received by the profession. The present edition has been rewritten in some parts, and some additions have been made, especially on diseases of the nervous system, but the size of the volume has been increased only about seventy pages. It is still, as heretofore, the most compact, yet comprehensive, text-book on medicine in the English language.—*Canada Lancet*, July, 1873.

Ever since the first edition was placed before the profession, in 1868, it has continued to rank as the leading American text-book.—*Chicago Med. Examiner*, July, 1873.

The reputation of "Flint's Practice" is well established, both in Great Britain and America, and there is no higher authority in our language, or, indeed, in any other, as a standard of medical theory and practice.—*Pacific Med. and Surg. Journ.*, July, 1873.

Flint's Practice of Medicine has become so fixed in its position as an American text-book that little need be said beyond the announcement of a new edition. It may, however, be proper to say that the author has improved the occasion to introduce the latest contributions of medical literature, together with the results of his own continued clinical observations. Not so extended as many of the standard works on practice, it still is sufficiently complete for all ordinary reference, and we do not know of a more convenient work for the busy general practitioner.—*Cincinnati Lancet and Observer*, June, 1873.

Since the publication of the third edition of this work the advances made in many of the departments of medicine necessitated a careful revision of it to place it where it is now, upon the highest vantage ground of authority in the clinical history and treatment of diseases. The great characteristics of this work are, its scientific accuracy and research, combined with astonishing succinctness, terseness, and simplicity of style. The student and practitioner, in referring to it in doubt and perplexity, will find the subject treated thoroughly and practically in a few pages. The work should be in every physician's library.—*Virginia Clinical Record*, June, 1873.

It is of course unnecessary either to introduce or eulogize this now standard treatise. All the colleges recommend it as a text-book, and there are few libraries in which one of its editions is not to be found.—*Chicago Med. Journal*, June, 1873.

Its excellence has been generally admitted; each edition has given more and more evidence of the care with which its author records facts observed in his extensive clinical experience; and the present fills a hiatus in the original plan of the work, which renders the present issue the most complete and perfect of any similar book in the English language. Without detracting from the merits of other works, we unhesitatingly say that no medical library can be considered complete without a copy of "Flint's Practice," any more than could a law library in California be thought complete without a copy of the Statutes of the State. It is indispensable to both practitioner and student, and we are glad to record that it has been adopted by a large majority of our educational institutions throughout the Union, as a text-book.—*Western Lancet* (San Francisco), July, 1873.

HENRY C. LEA—Philadelphia.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on the Influence of Distension of the Abdomen on the Functions of the Heart and Lungs.* Delivered at St. Mary's Hospital, London, by FRANCIS SIBSON, M.D., F.R.S., Consulting Physician to the Hospital, etc.

My subject, gentlemen, is the influence of distension of the abdomen on the functions of the heart and lungs. Since the chest is divided from the abdomen by the diaphragm, which forms the floor of one cavity and the roof of the other, the ascent or descent of that movable partition while it enlarges one cavity encroaches upon the other. When the chest enlarges, it enlarges in two directions; one outwards over its whole circumference by the expansion of the walls of the chest, the other downwards by the descent of the diaphragm. When the abdomen is enlarged, it is enlarged also in two directions; one outwards and downwards with the extension of the walls of the abdomen, the other upwards by the elevation of the diaphragm. When the abdomen is extremely distended, the whole cavity becomes oval in form, or shaped like a balloon, as you may see in this diagram; the outer part of it presses outwards, and the upper part of it presses upwards. The cage of the chest is raised by this upward movement. The whole of this wide cone formed by the upper part of the large oval abdomen, acting upon the lower ribs, forces them asunder to the right and to the left, and lifts up the whole front of

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the cage of the chest. The more important effect, however, of this distension is to lift up the heart at the centre of the chest, and the right and left lung on each side of it. When these organs are raised, as the cage of the chest in front of those organs is raised also, the apparent elevation of the heart is much less than the real elevation.

Distension of the abdomen may be caused by the distension of the stomach, the colon, and the small intestines, either singly or in conjunction; by the presence in the cavity of the abdomen of gas and of fluid; by the enlargement of the liver; and by tumours and cysts.

Swelling of the stomach and bowels with gas is caused not by the secretion of the gas from the living structures, but by its formation from the food taken into the stomach. This diagram, taken from a poor woman who literally died from starvation owing to cancer in the œsophagus, presents a perfect clinical proof of what I have said. You will observe, that there is neither gas nor food in the whole digestive canal. The stomach is like an intestine. The great intestine is smaller than a small one. The food that is in the stomach, and the food that has passed from the stomach into the intestines, are the cause and source of the gas that they contain.

The heart, as you may see in these diagrams, rests upon the stomach When the stomach is greatly swollen, the heart and the lungs, if healthy, suffer but slight inconvenience when rest is preserved; but moderate exertion, and especially quick walking, or the ascent of a hill, will often bring great distress in the region of the heart, and even actual anginal pain passing down the left arm. When, as is frequently the case, the stomach is swollen in patients affected with Bright's disease, or with affections of the aorta or of the heart, the patient has great distress of breathing even when raised in bed, but especially if he lie down or exert himself. In all these cases (diagrams) there was great distension of the stomach, and they show the serious and too often fatal contest that takes place between the enlarged organs of the chest striving to get downwards, and the distended and enlarged organs of the abdomen striving to get upwards. The functions of both the higher and lower sets of organs—the thoracic and the abdominal—are seriously interfered with; but those of the organs of the chest are more seriously and more often fatally deranged than those of the abdomen. The heart and lungs are both removed upwards from the more ample space of the middle region of the chest into the contracted area formed by the diminishing cone of the chest. The heart suffers from its inability to expand downwards, and yet as it cannot send its blood through the compressed lungs, the right cavities of the heart become gorged with blood, as you may see in these drawings. Although in all of them the stomach and intestines are large and push the heart upwards, that organ is compelled to receive into it the blood that is sent from the whole system, which blood once received into the organ cannot be sent onwards through the lungs, the lungs having an additional obstacle to their expansion and to their reception of blood by being compressed upwards, owing to the elevation of the diaphragm.

In this case (diagram) we have, perhaps, as complete an illustration of the contest as any that I can give you—the contest between the organs of the chest and the organs of the abdomen. You will observe that the aorta, which is affected with atheroma, is very greatly dilated and greatly lengthened; it has come down so low that the lower end of it is on a level with the lower end of the sternum. The consequence is, that the left ventricle and the right ventricle are pushed solidly downwards by the lengthened aorta, and the interior of the heart is itself compressed downwards by this very agency. Of course this displaces the stomach downwards. But here we have a fresh contest from below. The stomach is distended unduly with gas; so is the transverse colon; and so are the small intestines. The liver itself is gorged with blood, owing to the impossibility on its part of sending the blood forward to the right side of the heart; and, to crown all, in this case, we have effusion into the right side of the

chest, displacing the heart to the side, and interfering with its work. Can we wonder that, under this accumulation of difficulties, this man died?

Here is another similar case. The man had aortic regurgitation. He was a labourer, aged 30, with a large athletic frame and an ample chest. He complained of shortness of breath, and of pain in the chest after a meal. This man would sometimes change rapidly from a state of comfort to one of extreme distress. Thus, on the 13th of July, when in these wards, he said that he never felt better in his life; and, on the 14th, all was changed, and a frequent cough, increased beating of the heart, and difficulty of breathing, rendered it impossible for him to sleep or to remain in the recumbent posture. This attack was associated with, and apparently caused by, great fulness of the stomach from eating.

Here is the case of another patient, a carpenter, with aortic disease. He suffered five years before admission from pain in his chest, especially after eating, and, on exertion, he felt as if "something were scratching him at the back of the breastbone." When in the hospital he still suffered pain in the lower part of the chest after eating, if he walked about, but not if he sat still. Here are other drawings, in which you will see an enlarged heart—enlarged owing to mitral and other diseases—and enlarged lungs caused by the enlarged heart. In one instance, the enlargement of the lungs was supplemented by extensive pulmonary apoplexy; and, in another, the heart was adherent and the right lung was contracted owing to bygone pleurisy; while in this case, the lungs were enlarged to a very great extent by emphysema. In all these cases the stomach, and to a less degree the intestines, lifted the heart and the lungs upwards, compressed the whole of the organs of the chest within a narrow compass, and interfered with their functions. In truth, we may see that the final close to the existence of all these patients was hastened by the distension of the stomach.

Each organ holds within itself a reserved force many times greater than the amount of force that is brought into play in the ordinary and quiet demands of life; but, in proportion as those demands are increased, more and more of the reserved powers are brought into use. The lungs —I have ascertained this in my own person—possess sixteen times as much breathing power to be used during violent exertion as they employ when the body is at rest. Thus, the patient affected with aortic disease, to whom I referred, felt no discomfort in the heart after food if he sat still, for then the heart had sufficient force to do its work; but when he walked after food he felt pain in the heart, for that organ had no reserve force to resort to, and so, by making violent and undue exertion, like a wrenched muscle, it excited pain within itself—in short, angina pectoris.

In considering the treatment of this distension of the stomach that thus confines the action of the heart and lungs, I need not detain you with the well-known medicines often so serviceable on such occasions. Some of these, such as the warm and cordial tinctures, camphor, and, perhaps, chloric ether, are agreeable; some, if efficient, are repulsive, such as turpentine, assafœtida, and, perhaps, creasote; while others are neutral, such as that valuable remedy guaiacum. I have before me the case of a gardener who had mitral disease; he had, however, a complication of maladies—syphilis, subacute rheumatism, and ague. He complained of fluttering of the heart and great distension of the stomach. He was relieved by the use of turpentine and guaiacum.

Charcoal is of little or no use in these cases. Dried charcoal, owing to the immense distribution of its surface, absorbs a large amount of gas; but wet charcoal loses its subdivision. Suspend a piece of dry charcoal in the stomach, and of course it will absorb the gas. The very act of swallowing causes it to become wet; when it drops down into the stomach, it becomes more wet still, and it is clearly out of the laws of possibility for that charcoal there to absorb one cubic inch of the immense mass of gas that is in the stomach.

I wish, however, rather to bring before you the other and non-medicinal means

that may be employed for the relief of the distension of the stomach with gas. This gas, as I have said, is secreted, not by the structure of the stomach, but by the food. If you cut off the supply of food, sooner or later, when that already in the stomach has passed away, relief will be obtained. But we cannot cut off the supply of food; therefore we must select such kinds of food as give the greatest amount of nourishment, and tend to set free the least amount of gas; for, although every kind of food will produce gas when the powers of digestion are weak, yet some kinds will do it much more freely than others. My rule is simply this: Take no bread, but eat biscuits instead. Take no solid vegetables, but use lemon-juice freely. Squeeze some of it over all your food. Shun soups, cucumbers, and fruit. Prefer meat, fish, fowl, or game, tender, but perfectly fresh, lightly cooked, and juicy—not hard and dry; or take it thoroughly soft and fragrant, as sent up by the hand of the artist. Take no rich sauces, or, indeed, any other sauce, than wholesome, fresh lemon-juice or mushroom ketchup; no twice cooked, or salted, or seasoned, or dried meat. Let everything be fresh and savoury. Under this simple rule of substituting biscuit for bread and fresh lemon-juice for vegetables, relief will often be obtained from distressing symptoms indicating danger. Let the food be agreeable to the eye, fragrant to the nostril, and savoury to the palate; and, invited by these senses, the influences of the nervous system will bring those juices into the mouth and stomach that are required for the digestion of the food—juices that are attracted if the food is attractive, repelled if the food is repulsive.

The rules, however, that I have given are but a portion of the proper treatment. Each case stands upon its own grounds, and must be treated according to its own demands. In treating each case, the laws of nature must be strictly enforced. Departure from those laws has brought on the illness; and in a renewed obedience to those laws, we shall usually find the best road to restoration of health. The right treatment of disease is neither expectant nor heroic, but is a treatment founded on knowledge, a watchful interest in the patient, moderation, and good sense.

One patient had been quite well until the previous April, when, one night, after a late supper, he woke up fighting for breath and life. He raised a thin and frothy phlegm, which was stained the next day with blood. He had suffered from no such attack for a month; but he could not lie down; he was short of breath, and felt, as he said, inflated—blown out—sometimes almost ready to burst. His heart was very large, its action being powerful. There was a doubling of the first sound over the ventricles, and feeble first sound, and loud second sound over the aorta. Effusion was present in the right side of the chest. There was a mere trace of albumen in the urine, but I found in it one large waxy cast. The kidneys were the true seat of the disease. Under the influence of the restricted diet I have described, and the general treatment, he lost the distension of the stomach; he could lie down on one pillow; he had no return of the sense of suffocation; and the fluid in the right side of the chest disappeared. The condition of the heart and that of the kidneys were not materially altered.

Here is another case of a patient (represented in this little diagram) who complained of "trouble" over the region of the heart. His abdomen was swollen; the stomach displaced the lower boundary of the heart upwards, so that it was situated in the fourth space. Subsequently, under a restricted diet, the upper boundary of the stomach and the lower boundary of the heart fell almost to the extent of an inch. The heart, having gained an increase of space, lost its "trouble;" and, though he was ill in other respects, the distension of the stomach disappeared.

Another diagram that I have here shows a more marked difference in the position of the heart during the second, as compared with the first, observation made eleven days previously. This patient complained that he had pulsation through the body, and that the heart stopped for two or three beats. This state was worse after

dinner, and was accompanied by fulness in the head. The irregular action of the heart disappeared with the descent of that organ that followed upon the diminution of the size of the stomach.

The last case to which I shall refer gave me at first some anxiety from its obscurity. This patient was a fine-looking man, with a large but not overgrown frame. He was of good colour and complexion. He complained of great shortness of breath, and he had a dropsical swelling of the right lower limb. The only unhealthy condition that I could discover in his internal organs was a distension of the stomach from gas. I will allow that I felt as if there must be some other cause, but I could find none. He took a dry diet; and although a week later, the stomach was less distended, yet his right leg was still swollen, and his breathing short. He persevered, and gradually lost the shortness of breath and the swelling in the right leg, and he regained his usual good health.

Distension of the colon is illustrated in these diagrams. You will observe that, in these instances, the transverse colon is no longer transverse. In these they all form a loop from above downwards, the tip of the loop being midway between the navel and the pubes. You will also see that the ascending colon increases greatly in length, starting from its head in the crest of the ilium. You may remark, on looking at these two diagrams, that, inasmuch as the top of the ascending colon immediately abuts upon the lower surface of the liver, the elongation of the ascending colon directly elevates the liver. So, also, with regard to this double flexure of the transverse colon. In one instance, you see the loop is single, and in another the loop is double. You will see that the descending colon is not in any of these cases, except perhaps in one, very greatly distended; yet there is in all of them great distension. In this diagram, representing a back view, the descending colon is distended quite as much as the ascending and transverse are in any of the others. In another instance, you see that the liver on the right side, and the stomach and spleen on the left, are both lifted up, as it were, upon the top of the lengthened colon. You may remark in these cases that the liver rises very high; in one instance, quite into the lower end of the fourth space; and in another, as high as the third space. And you may observe how much higher the upper boundary of the right wing of the diaphragm, which is lifted up by the liver, is than the upper boundary of the left wing of the diaphragm, which is lifted up by the stomach. The result is, that in these cases we have the heart pushed over to the left side, owing to the elevation of the liver, which tends to displace the heart to the left; and while the right lung is compressed from below upwards, the left lung is encroached upon by the heart, which is pushed aside by the liver.

You will at once see, from the study of these diagrams, how seriously distension of the colon must affect the organs of the chest, not only the lungs, but also the heart, by displacing that organ to the left; whereas, in the case of the stomach, its displacement tended rather to the right.

The next set of cases that I shall bring before you are those in which the stomach, the colon, and the small intestines are all distended. In this diagram, distension of the stomach is not extreme, but there is extreme distension of the ascending, the transverse, and, I believe, the descending colon, and extreme distension of the whole of the small intestines owing to peritonitis. You will observe that this diagram shows, better than any other, the oval shape that the distended abdomen assumes. Contrast it with this one, which shows the shape of health, like a reversed sugar-loaf rounded at the top, while the other is a true type of complete abdominal distension, being a perfect oval. In this other case, where the abdomen is perfectly flaccid, you have neither the reversed sugar-cone shape of health, nor the oval of distension, but a double concavity. The centre of the abdomen is narrower than either the top or the lower part. We see here, in another diagram, the effect of immense distension upon the walls of the chest. See how these cartilages are pushed aside to the left, and those to the right, so that there is an addition of nearly

one-third to the width from side to side. Again, you may perceive that the cage of the chest is lifted up by this great oval mass below pressing upon it from below, and this will account for the remarkable fact that, although we have the heart and lungs so elevated by the diaphragm thus pushed up, yet the lower boundary of the heart is very little above the lower boundary of the sternum; the lower boundary of the lungs is very little above the position in which we often find it in a perfectly healthy body. If you look at the aorta you will see how completely that artery has been driven over to the right side. If you compare the breadth of the heart from side to side, with the length of the heart and the great vessels from below upwards, you will see that the whole organ is, in point of fact, compressed upwards. In health, as you may see in several of these instances, the apex of the heart is lower than the lower boundary of the heart behind the lower end of the sternum. In this instance, the apex of the heart has been lifted upwards and is a third of an inch higher than the lower boundary of the heart at the end of the sternum.

We find in these cases—that the heart and the lungs are put to an immense disadvantage—that the lungs are compressed and the reserved air driven out of them—that the heart is compressed and the blood driven out of it—that the ventricles are diminished in size and are incapable of receiving so much blood as they did before—that there is an obstacle to their action, and that they are incapable of sending out the blood that they have already received with the ease that they did before. Again, if you look at the walls of the chest and the diaphragm, you see what an obstacle is put to the very limbs, by which, as it were, the lungs expand and the heart is moved. The cartilages and ribs are pushed aside and lifted upwards. The cage of the chest has reached the limit of its powers by the elevation given to it, and permanently given to it, by the distension of the abdomen. Again, look at the diaphragm, lifted up by this immense distension. How can it act downwards? If the diaphragm is affected with peritonitis, the inflammation paralyzes the inflamed muscle. The whole contest is then narrowed to the smallest bounds; and the whole work of respiration must be done by the few ribs remaining unassailed at the top of the chest. In cases of peritonitis, respiration is what is very well called high. The whole of the breathing is performed by the laboured lifting up of the upper cartilages, the upper ribs, and the clavicles. All the muscles that act—the sterno-cleido, the scaleni, the levators of the ribs and the scapulæ—are hard at work, and, in spite of that, you see visibly in the face that the patient is undergoing chronic asphyxia, and must soon die unless his breathing is relieved.

Here is another case: A repetition of the other, but a little less extreme. It shows, in what I would call a rather beautiful and orderly manner, a series of tiers, one above another, the top one made by the distended stomach, the second by the circular curve of the transverse colon, and the third by the small intestines. Here is also another case, showing tier above tier in the same way, the intestines below, the transverse colon in the middle, the stomach above, and above that the heart. Here is also another, showing the intestines below, the transverse colon at the middle, and the stomach at the top, all pushing up the heart and lungs, and interfering with their work. I could show to you other cases, but these are sufficient.

The tendency of this great distension of the stomach and intestines is to push the heart directly upwards, to flatten the heart from below, and to displace it somewhat to the right side. You see in this diagram that the aorta, instead of being shielded by the sternum, lies almost entirely to the right of that bone. The pulmonary artery, on the contrary, instead of lying entirely behind the spaces, is almost entirely behind the sternum. A similar condition obtains in this other case. You see that the apex has been raised. It is nearly half an inch higher than the lower boundary of the centre of the heart, although, naturally, it ought to be half an inch lower than that lower

boundary. The position of the apex is the test of the extent to which the heart has been compressed upwards.

There are two means by which the treatment of great distension of the stomach may be met, independently of drugs; and I would say to you that when distension is extreme, drugs are worse than useless. They add, by their offensiveness, to the misery of the patient. These two modes are the insertion of the œsophageal tube into the stomach through the mouth, and the insertion into the stomach of the fine point for injecting morphia under the skin. I have the particulars of a case that occurred in this hospital—that of a man who had the most serious threatening of death in consequence of great distension of the stomach. The circumference of his chest was thirty-nine inches. We introduced the œsophageal tube, and a large quantity of gas escaped. The circumference of the chest was reduced from thirty-nine inches to thirty-seven, and for a time the man experienced perfect relief. Before this was done, he had great distress; after it, he was at ease. The relief lasted for some days. He had kidney-disease and various other serious affections; and after a time he died.

Another case, that I saw with the late Dr. Williams, of Swansea, was more fortunate. The patient had acute rheumatism of a low type. The stomach was extremely distended, and respiration was interfered with in consequence. Dr. Williams introduced the tube; a large quantity of gas escaped; the powers of respiration were restored, and gradually the patient recovered completely, lived for many years afterwards, and is, I believe, now alive. With regard to the other method—the insertion into the stomach of the fine point for injecting morphia under the skin—I have never had the opportunity of employing it, but I have been always ready to use it if required; and I believe, though I cannot put my hand on a case, that it has already been practised with advantage and success.

I now come to the question of the distension with gas owing to rupture of the intestine, one of the most formidable accidents that can occur. There are two classes of cases. In one class the distension takes place slowly, widening out the abdomen in an oval form; while in the other class the distension takes place rapidly; and, inasmuch as the muscular walls of the abdomen are the sentinels of the cavity, they do not yield, and the abdomen does not assume the oval form that it does in cases of inflammation of the intestines and stomach, with distension of those parts. The result is that the whole of the distending force is expended upwards, and the liver and stomach are elevated to an extreme degree. You may see that the top of the liver and the top of the stomach are seated just below the third cartilage, and the lower boundary of the right lung immediately behind the fourth cartilage. All the organs are pushed up into the highest part of the chest; and, as the chest is a cone narrowing from below upwards, they are pushed up into the narrowest part of the house that they inhabit. You will also see that, on the whole, the right side is more affected than the left; and thus the liver, being a large and massive organ, is pushed upwards to a greater extent than the stomach. Thus in these two diagrams the right lung is much more highly raised than the left, and the apex of the heart is much less raised in proportion than the centre of the heart at its lower boundary.

I next come to distension of the abdomen from the effusion of fluid into the cavity. I am not rich in specimens of this kind of abdominal distension, but here is a very good example, admirably drawn by our old friend the artist, Mr. Fairland. You may see here that the whole of the interstices of the abdomen—especially the backward interstices—are filled up with fluid. You may mark the intestines and the stomach floating forwards, and the liver sinking backwards. You may see how the liver, instead of, when the stomach and intestines are distended, being pushed up so as almost to thrust itself and intrude upon the heart, drops away from the diaphragm, and leaves the fluid to make the elevation. You may mark how the whole abdomen

assumes an oval form. The result is that the heart is pushed up, that the right lung is pushed up, and that the left lung is pushed up, all at about an equal pace, and you have, as the effect of all this, compression of those organs, and difficulty on their part to do their work. If those organs are at rest, and if there be neither heart disease nor lung disease nor Bright's disease, then the patient may be able to lie down, and to go through his days and nights in bed, without shortness of breath. As a rule, however, patients who have a large amount of fluid in the abdomen are compelled to sit up. And this gives you a brief explanation of the inability to breathe in a recumbent posture in many of these cases. When the patient lies down, the fluid bears at once upon the diaphragm and presses it upwards. The right lung, the left lung, and the heart are compressed, and all the difficulties of respiration are most seriously increased; but when the patient sits up, then the fluid drops downwards to the lower part of the abdomen; the pressure is removed from the diaphragm and from the heart and lungs, and respiration can go freely on.

In cases, however, where you have disease of the heart, disease of the lungs, or disease of the kidneys, unfortunately the very cases in which fluid is often thrown out into the abdomen, and the very cases in which there is distension of the stomach and intestines, the mischief done is very great, and the relief to be afforded by any slight treatment is trivial.

I have one case in which the effect of the removal of a very little fluid lets in a flood of light upon the terrible influence of distension. It is the case of a man who was in the Albert Ward. He was a labourer, aged 28. He came in with aortic and mitral regurgitation, great enlargement of the heart, and distension of the abdomen. He complained of pain about the heart and great difficulty of breathing. The urine was scanty, amounting to only twenty ounces in the twenty-four hours; and the quantity was not increased by the treatment adopted. The abdomen was greatly distended, its circumference measuring forty-one inches; and this distension was chiefly due to swelling of the stomach and intestines with gas. The quantity of fluid was not great, but it was determined to remove as much as possible. An incision was made in the skin four inches below the navel; and, to avoid the intestines, which were perilously near the surface of the abdomen, the point of the trocar was not pushed backwards, but obliquely downwards. At first, only a teaspoonful of serum flowed; but we had been prepared for this; and inserted a female catheter through the canula, and so pressed gently backward the wall of intestine that was dropping upon the end of the canula so as to stop it up. Seventy-five ounces flowed pretty quickly away through the female catheter. The measurement of the abdomen fell from forty-one to thirty-eight and a half inches. The man passed twenty-four ounces of urine that night. The next day, he could breathe with perfect ease, and he felt in comfort. The quantity passed in the twenty-four hours increased from twenty ounces to seventy-four on the second day, eighty-six on the third, and ninety on the fourth. The treatment in all other respects was absolutely unaltered. The improvement continued for a time; but at the end of three weeks the urine lessened, and the fluid in the abdomen increased. One hundred and fifty ounces were withdrawn; but, although this produced relief and some increase of urine, the patient became gradually worse, and died about five weeks afterwards. In this case, the distension of the abdomen acted, as it were, as a ligature, and prevented the secretion of urine. As soon as this ligature was removed by the withdrawal of a moderate amount of fluid, the quantity of urine increased.

I find that my time has expired; and you know my old maxim about not transgressing the allotted period. The other subjects that I had intended to bring before you were, ascites associated with cirrhosis of the liver, when its effect on the functions of the heart and lungs is comparatively trivial; ascites associated with disease of the heart, when its effect is more serious; ascites associated with

Bright's disease, when its effect is more serious still, and more difficult for the physician to combat; and the influence of enlargement of the liver upon the functions of the heart and the lungs. Pure enlargement of the liver produces very little mischief to the heart and lungs, and for this reason: if there be no distension of the intestines, the liver, owing to its bulk, drops downwards upon the intestines and compresses them; it, therefore, does not push upwards and compress the heart and lungs. But if there be enlarged intestines and a distended stomach, and fluid in the abdomen, pressing the liver upwards, then, if the liver be also large, you get, besides that accumulated series of causes of distension of the abdomen, this additional one. In these diagrams you have a fivefold series—the first made by the liver, the second by the stomach, the third by the transverse colon, the fourth by the small intestines, and the fifth by the fluid. But, if the right upper lobe of the liver be enlarged by an abscess, or a hydatid cyst, or a large cancerous mass, then the liver, ascending into the right side of the chest, forces the heart over into the left side, and compresses the right lung directly, and the left lung laterally, through the medium of the heart.

Gentlemen, I need not tell you that I have touched upon a subject, to illustrate which would require a series of practical lectures, but I shall be well rewarded if I have awakened in any of your ingenious minds the desire to study, in the mortuary and in the wards, the various causes of distension of the abdomen, and the various and often serious and even fatal results that this distension may induce on the functions of the heart and lungs. The clinical study of disease is inexhaustible. It requires knowledge, patience, skill, an increasing interest in the welfare of the patient, an increasing interest in the study of his disease, as you watch it. Clinical study is ever living, ever fresh. It brings that true power that depends on true knowledge and wisdom, to him who has diligently pursued it, and who still pursues it to the end of his career.—*Brit. Med. Journ.*, Aug. 2, 1873.

## HOSPITAL NOTES AND CLEANINGS.

*Malignant Disease of Kidney.*—Primary cancer of the kidney is almost always of the encephaloid variety, scirrhus and epithelioma being so rare that only one or two cases have been recorded. The diagnosis of a malignant tumour of the kidney is often very perplexing, owing to the adhesions which the mass contracts with the surrounding tissue and organs, and to the great displacement of the other abdominal viscera. Frequently an examination of the colon, contrary to what is laid down in books, affords only a negative result, which is partly due to the displacement of the bowel, and partly to its compression between the tumour and the abdominal parietes. Another disputed point in primary renal cancer is the average duration of life. The assertion of some observers, and especially Walshe, that it runs a more rapid course than any other internal cancer, seems to be opposed to the evidence of a large number of cases. It has, indeed, been shown that its duration is longer than almost any other variety of internal cancer, which may be attributable to the duplicity of the organ, so that compensatory hypertrophy takes place very readily in the healthy organ when the other is disabled by disease. In the following case the classical symptoms were present—namely, hæmaturia, and a tumour in the abdomen; but even these symptoms are not absolutely diagnostic of renal cancer, for Dr. William Roberts has observed a case where profuse hæmaturia coexisted with an enormous splenic enlargement.

R. H. P——, aged four years and five months, healthy and well developed. The symptoms first noticed were pain and tenderness of the abdomen, and were attributed to worms. An ordinary worm-powder was given, and then blood was noticed in the urine, also a quantity of albumen. Upon examination a tumour was found on the left side, extending from the kidney towards the pelvis. The tumour grew rapidly, causing great distension of the abdomen. The child died six weeks after the first symptoms were noticed. Upon making a post-mortem

examination, a tumour was found occupying nearly all of the left side of the abdomen, and displacing the viscera. The liver was found much enlarged and covered with tubercles. The other organs were fairly healthy. The tumour weighed nearly two pounds, and was much like the shape of a kidney, and will be sent to the museum of the Royal College of Surgeons.—*Lancet*, July 26, 1873.

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*Small Painful Tumour connected with the Internal Saphenous Vein.*—Mr. R. Clement Lucas reports (*Brit. Med. Journal*, August 2, 1873) the case of A. N., aged 35, who came as an out-patient to Guy's Hospital, July 12, 1873. She complained of a small, painful swelling, situated about four inches above the inner ankle, and half an inch behind the inner margin of the tibia. This, she stated, had been first noticed at least nine years previously, and had at intervals caused her a good deal of pain. During the last two years she had often suffered intensely from throbbing, burning, and darting pains, at the site of the swelling; and it was on this account that she sought advice. The tumour was sensitive to gentle pressure, but might be firmly squeezed laterally between the finger and thumb without causing pain. When, however, it was directly pressed upon, a sensation was excited along the inner margin of the foot. It was removed by the dresser, without the aid of chloroform. The tumour was about the size of a large pea, white, firm, and opaque, with a depression on one side like a hilum, to which a small filament remained attached. Under the microscope this filament was found to consist of nerve tissue. The tumour itself was composed of fibrous tissue arranged in variously distorted coils and loops, and the vessels pervading it were seen to be surrounded by concentrically arranged fibres.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Treatment of Colles's Fracture.*—Dr. R. M. Hodges, in a clinical lecture on Colles's fracture, recently delivered at the Massachusetts General Hospital, stated (*Boston Med. and Surg. Journ.*, June 5, 1873), that among all the splints that have been proposed, there is none of more general usefulness than what is called, in this hospital, "a spoon splint"—a straight splint, carved to fit the dorsal aspect of the arm and hand. It extends from the elbow to the ends of the fingers, and is accompanied by an inside splint, shorter, but reaching from near the elbow to the middle of the palm. These should be as broad, or broader than the arm, and are best padded with towels. Any provision, either in the splint or the padding, intended to wedge apart and maintain the interval between the radius and ulna is useless. There is no interval at the point where this fracture occurs. The splints should be adjusted without previous bandaging of the arm, and held in place by tapes or inch-wide strips of adhesive plaster. A roller bandage is then applied, and if the tapes or adhesive strips have been properly secured, this should not be put on too firmly. Tight bandaging is a cause of synovitis in the sheaths of the tendons.

A pistol-shaped splint is occasionally used when there is much lateral displacement of the hand, but its efficiency in correcting this deformity is not very great.

Four to six weeks, according to the age of the patient, should be allowed for the wearing of splints, and the bandages should be changed as seldom as possible. If swelling and pain persist, the splints should be continued even longer than the time first named. In this hospital, most of us believe that passive motion, so long as pain and tenderness remain, only aggravates the condition it is designed to remedy.

The articular inflammation, which is frequently set up by the proximity of the injury to, or by actual implication of, the joint, is a source of stiffness which is sometimes unjustly charged to mismanagement by the surgeon. An adhesive inflammation of the sheaths of the tendons is another, and perhaps more frequent cause of stiffness. The rigid and deformed wrist and fingers, which may follow skilful treatment, must be anticipated by any one who takes upon himself

the care of this fracture, and advanced age in the patient adds to this liability. Mere deformity, however, does not interfere with the ultimate usefulness of the limb. Pains should be taken at the outset to forewarn those interested of these possible and often wholly unavoidable contingencies.

Prolonged bathing of the hand and wrist in warm water, and gentle friction with an inelegant but very useful liniment, composed of equal parts of lime-water and linseed oil, will do more to limber and soften the fingers and wrist than any passive motion, however unrelenting. It should be remembered that the flexor tendons of the fingers, both superficial and deep, run in one synovial sheath, and that any attempt to remedy stiffness in their movements can be accomplished more readily by flexing each finger separately, than by bending them altogether, as is frequently done. If there is persistent pain, which, unfortunately, often happens, even the motion produced by rubbing is best omitted until irritation has subsided. Any violence that excites inflammation is prejudicial.

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*Death from Chloroform.*—In the *Clinic* for August 9, it is stated, that a young and apparently healthy looking German presented himself at the office of Dr. Wm. H. Mussey, of Cincinnati, to have three or four fingers dressed, after an accident by machinery. Chloroform was administered, and before full narcosis was established the patient was seized with convulsive tremor and immediately succumbed.

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*Boylston Medical Prizes.*—At the meeting for 1873, of the Boylston Medical Committee, prizes of one hundred and fifty dollars each were awarded to David T. Lincoln, M.D., of Boston, for a dissertation on "Electro-Therapeutics," and to William C. Dabney, M.D., of Charlottesville, Va., for a dissertation on "The value of Chemistry to the Medical Practitioner."

The following are the questions proposed for 1874:—

1. The best method of preventing the development and spread of smallpox.

2. The development and extension of malignant disease.

Dissertations on the above subjects must be transmitted to J. B. S. Jackson, M.D., Boston, on or before the first Wednesday in April, 1874.

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*Jefferson Medical College.*—The Trustees of Jefferson Medical College having requested Prof. Joseph Pancoast to withdraw his resignation of the Chair of Anatomy in that institution, he has complied with the request, and will accordingly discharge the duties of the chair during the ensuing session.

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*University of Michigan.*—The following preamble and resolutions were passed by the Board of Regents of this Institution at a late meeting:—

Whereas, The Legislature of the State of Michigan at its last session re-enacted the law of 1855, requiring the appointment of Homœopathic Professors in the Medical Department of the University; and whereas, it has always been claimed by the Board of Regents that the law was an infringement upon the rights and prerogatives of the Board; and whereas, the Supreme Court of the State has refused to grant a mandamus requiring the Regents to comply with the law, thereby substantially confirming their action, therefore,

*Resolved*, That we maintain the position heretofore taken, and decline to make the appointments required by the law.

*Resolved further*, That we do this in no spirit of factious opposition to the apparent will of the Legislature, but because we believe the true and best interests of the University demand it.

*Resolved*, That we re-affirm the former action of the Board expressing a willingness to take official charge of an independent school of Homœopathy, and connect it with the University, whenever the means shall be provided for the payment of its professors.

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*Medical and Surgical History of the War of the Rebellion.*—It is stated, that in many parts of the country persons anxious to consult this valuable government document are unable to obtain access to it, and that even a copy is not to be found in many of the public libraries. This

statement may seem inexplicable when it is remembered that Congress voted 3000 copies of the work, of the 5000 printed, for the use of its members; but an explanation satisfactory to many will be found in the fact, that in Washington copies are exposed for sale at prices scarcely more than nominal, and that the trade there is overstocked, and a market for the work has to be sought elsewhere.

How it happened that these copies, which are said to have cost the government $125 apiece, were not distributed among the people, as was intended, but got into the hands of Washington book-dealers, and how they are able to offer them for sale at prices vastly below the original cost, may, perhaps, be explained by honourable members of Congress.

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## FOREIGN INTELLIGENCE.

*Nephrotomy.*—Mr. CALLENDER removed, last week, a large calculus from the kidney of a woman about forty years of age. As the case is to be published in full in the *St. Bartholomew's Hospital Reports*, we give here only a short notice. The patient was admitted under Dr. Andrews, suffering from profuse pyelitis; she was very weak, and greatly emaciated. By palpation through the thin abdominal walls, a large, smooth, hard tumour could be felt in the right lumbar region. It was rather elastic, but not distinctly fluctuating, and resembled somewhat in shape a greatly enlarged kidney. It was at first thought that there might be malignant disease of this organ; but it was found that at times the tumour increased greatly in size, coming forward almost to the umbilicus, and then suddenly collapsed again. It could not be clearly proved that this partial collapse of the tumour was followed by any marked increase of pus in the urine, nor could any stone be felt when the tumour was thus diminished; but there was a distinct history of renal colic, and, after full consideration of the case, Dr. Andrews and Mr. Callender came to the conclusion that the symptoms were due to the presence of a large stone in the pelvis of the kidney, and that, as the patient was evidently sinking under the constant drain of pus, the removal of the stone by operation offered the only, though slight, chance of recovery. Mr. Callender accordingly made an incision opposite the outer edge of the quadratus lumborum, nearly as if for colotomy. On reaching the back of the tumour, a trocar was introduced, and a quantity of puriform fluid drawn off; the opening was then enlarged, and an oval calculus, nearly of the size of a hen's egg, was extracted. Its weight, taken roughly after the operation, was two ounces and a quarter. The patient rallied somewhat during the first two days, but quickly relapsed, and died on the third day. Unfortunately, no *post-mortem* examination could be obtained.—*British Medical Journal*, July 5, 1873.

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*Chloride of Potassium in Epilepsy.*—Dr. LANDER uses (*Scalpel*, Belgium) chloride of potassium instead of bromide of potassium in epilepsy. He mentions the following advantages in the employment of the substance: It is more active, is but one-sixth of the cost, and has not the secondary effects of the bromide. He begins with small doses, but has been able to continue the use of the substance for months without any inconvenience, in daily doses of from one drachm to a drachm and a half. According to Dr. Lander, bromide of potassium is transformed into the chloride in the stomach. This is, therefore, an additional reason for prescribing it at once in this latter form.—*Lancet*, July 12, 1873.

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*Chloral in Puerperal Eclampsia.*—M. DUGARDIN extols (*Gaz. Méd. de Paris*, Feb. 1), the good effects of chloral in puerperal eclampsia and protracted labour. He thinks that it will replace chloroform in many cases, having the advantage over this latter of being employed where we require to keep the patient for a long time under the influence of some anæsthetic. In those cases of very nervous women, where the pains during the first stage of labour are very severe, or recur very frequently, and cause much unne-

cessary suffering and waste of power, chloral acts very beneficially, diminishing the frequency and intensity, but not the efficacy of the pains—thus shortening the duration of labour and lessening the shock to the system.—*Med. Times and Gaz.*, March 15, 1873.

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*On the Treatment of Gonorrhœa, and especially Gleet, by Medicated Bougies.*—M. G. Lorey gives a detailed result of eighty cases of acute gonorrhœa, and of twenty cases of chronic gonorrhœa treated with Reynoal's medicated bougies at the hôpital du Midi. These bougies are made of gelatine and gum; the gelatine forms the skeleton, the central and resisting portion; and the gum, mixed with the remedial agent, is spread on the surface. They are about six inches in length, and of a diameter of about one-fifth of an inch. Their consistence varies with the temperature, more or less soft; but by dipping them in cold water they can be readily passed into the urethra without causing pain. M. Lorey has found the opiated or belladonized ones very efficacious against chordee; each one contained about three-fourths of a grain. Almost immediately after the introduction of the bougie the erection subsided, and subsequent micturition was less painful. In the first stage of acute gonorrhœa, he has obtained the following results: 1. It renders micturition painless, or comparatively so; 2. It allays or prevents chordee. But, in the second period, the belladonized sulphate of zinc bougie has not been as efficacious as anticipated. However, it presents the following advantages: 1. Its use is more simple than the injection; 2. Under certain circumstances it permits the discardure of the use of injection; 3. As they require an hour to melt in the urethra, their therapeutical action on the mucous membrane is prolonged. The observations made on sixty cases led him to arrive at the following conclusions: 1. The opiated or belladonized bougies are indicated in the first days of a gonorrhœa, to allay and prevent chordee, to render micturition painless; they have a double action; they first allay the pain, and they isolate the inflamed parietes; 2. In the second stage the sulphate of zinc, or the belladonized sulphate of zinc bougie is really efficacious, but does not appear to be much more so than analogous injections. In chronic gonorrhœa or gleet, their efficacy is unequalled by any other treatment. The twenty cases submitted to that treatment all recovered; requiring, on an average, the introduction of but nine bougies. This rapid curative action of the bougies can be readily explained by its double action; the three-fourths of a grain of sulphate of zinc contained in each has an undoubted therapeutical action on the chronically inflamed mucous membrane; moreover, they act mechanically, by remaining in contact with the diseased membrane, acting as an irritant body, modifying, by its presence, the vitality of this membrane. It might be suggested that the success of the treatment, in these cases, was due, in a great measure, to the hospital regimen, but this applies, *à fortiori*, to acute gonorrhœa. It has been objected that this bougie might induce orchitis, but its irritating action is but temporary, and necessarily modified by the belladonna; moreover, in the eighty cases treated with them, there did not occur a single case of orchitis.—*Amer. Journ. of Syphilography and Derm.*, April, 1873.

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*New Means of Dilatation in Stricture of the Urethra.*—It simply consists in the employment of a column of liquid about twenty metres high, established by means of a funnel, and containing about a pound and a half of water (boiled at 25° or 27° C.), and suspended above the patient's bed. An India-rubber tube (about two metres long), and provided with a cock in the middle of its length (so as to moderate or suspend the current of water), and having, at its end, a small glass pipe like an ordinary syringe, which is to be introduced into the meatus urinarius, connects the apparatus with the penis. The glass end being introduced, the cock is more or less opened at will, and slight pressure is exerted on the glans, to prevent the water from running outside. The water in the funnel is then forced down

by its own weight, and runs down drop by drop, dilating the stricture without pain, and, through its local and antiphlogistic action, rendering the urethra pervious to sounds and bougies. The patient can, himself, apply the apparatus three or four times a day, and when it is removed the surgeon has only to make use of his sounds or bougies.—*Lancet*, Aug. 2, 1873, from *Mouvement Médical*.

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*New Mode of administering Cod-liver Oil.*—Numerous attempts have been made to render cod-liver oil less disagreeable, either by gelatinizing or solidifying it, but only with partial success. The system of capsules seems to answer best; but the great objection is the number of these which must be swallowed. Now it would seem that Messrs. Carre and Lemoine have contrived to incorporate the oil with *bread*. Each pound of bread contains a little more than two ounces of the oil or five tablespoonfuls, and three ounces of milk. Small loaves are also made which contain only two tablespoonfuls, and which, altogether, weigh only five ounces. These loaves are beautifully white, look extremely well, and have hardly any taste. Both children and adults eat them very willingly. In M. Bouchut's ward, at the Children's Hospital, in Paris, thirty-four small loaves are brought every morning, and are looked forward to with much anxiety by the children for breakfast. They have been largely used among private patients, and no one complains of any disagreeable taste. Five or six tablespoonfuls of oil may thus be given per diem, incorporated with the bread taken with the usual food. —*Lancet*, August 2, 1873.

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*Subcutaneous Injections.*—Dr. Constantin Paul recommends glycerine as a dissolvent for subcutaneous injections. He considers it to be far superior to water, alcohol, etc.; it is neutral, can be kept easily, and is, of all liquids, the one which approaches the nearest to the composition of subcutaneous cellular tissue. Glycerine is, indeed, almost a normal substance for cellulo-adipose tissues.—*Lancet*, Aug. 2, 1873.

*Administration of Perchloride of Iron.*—Dr. H. L. Snow states (*Brit. Med. Journ.*, June 28, 1873) that the astringent metallic taste long remaining in the mouth after the administration of tincture of the chloride of iron, the flavour of which is not very imperfectly disguised by the syrup or spiritus chloroformi with which it is usually ordered, may be altogether obviated by the substitution of a small quantity of glycerine (about half-an-ounce to an eight-ounce mixture).

—

*Dressing with Magnesia.*—Dr. Ohleyer advocates, in *Allgemeine Med. Cent. Zeitung*, No. 47, 1873, the use of magnesia, which he has found very successful in the dressing of certain ulcers when fermentative processes retarded healing. Magnesia neutralizes the acids present, prevents the access of oxygen to the surface, and protects the granulations. The author especially applies it to (1) atonic ulcers; (2) cases in which the skin is without epidermis and in which there is danger of suppuration; (3) inflamed and painful sores; (4) wounds which require to be stimulated or to be withdrawn from the influence of air, or in which suppuration should be diminished or modified. Dr. Ohleyer has also used magnesia with good results in erysipelas of the face, as an isolating substance.—*Lancet*, July 12, 1873.

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*Means of diagnosticating Lipomata.*—A character peculiar to lipomata resides in the property belonging to all fatty tumours of hardening under the action of cold. When, after the use of ice or the ether spray, in the case of a doubtful tumour, the growth is felt to become harder, the presumption is that the case is one of lipoma.—*Lancet*, August 2, 1873, from *Rev. Méd. Phot. des Hôpitaux*.

—

*Death from Chloroform.*—An old, but hitherto unrecorded, case of this was reported (*British Med. Journal*, for July 19, 1873) to the South-western branch of the British Medical Association. In the remarks which the case drew forth, two gentlemen (out of a meeting of twenty) admitted that they each had had a simi-

lar case of death from chloroform during a capital operation; but in neither of the two cases did the immediate cause of death gain publicity.

—

*Mortality in Parturition.*—M. Ernest Besnier has given some important statistics in regard to the mortality of parturition in Paris, derived from authentic documents furnished by the director of l'assistance publique. During the first quarter of 1873 of 1656 women delivered in hospitals there were 67 deaths or 4 04 per cent. Of 616 sent by the administration to be attended by city midwives, there were 8 deaths or 1.29 per cent. Finally, of 2868 women delivered in the city by the midwives of the bureau of charities, there were 11 deaths or 0.37 per cent.—*Revue de Therapeutique*, June 15, 1873.

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*On the Development of the Great Cholera Epidemics.*—Dr. Tholozan, Physician to the Shah of Persia, read a paper before the Academy of Medicine, on cholera, in which he stated that India is not the sole focus of cholera, but there are other centres of irradiation, among others, Afghanistan and Turkestan.

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*The Cattle Plague.*—The cattle plague, it is stated (*Brit. Med. Journ.*, July 19, 1873), has broken out afresh in Russia. The Russian government has forbidden the import and export of cattle or meat, as well as all animal substances, except milk, butter, and cheese, across the infected portion.

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*An International Pharmacopœia.*—Dr. De Cristoforis Malachia, Physician to the Great Hospital of Milan, and M. Lodovic Zambeletti, chemist and pharmaceutist in Milan, have issued a circular to various scientific societies, notifying them that the proposal for a universal pharmacopœia will be discussed at the Medical Congress, which is to assemble in Vienna in the course of this year.

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*British Medical Association.*—The forty-first annual meeting of the British Medical Association was held in London, August 5, 6, 7, and 8, under the presidency of Sir William Fergusson. The meeting was the largest ever held, about three thousand members, including a number of distinguished foreigners, being present. The following addresses, in addition to the president's address and the addresses of the presidents of the sections, were delivered. Address in Medicine by Dr. Edmund Parkes; in Surgery by Mr. John Wood; and in Physiology by Dr. Burdon-Sanderson.

The next annual meeting will be held in Norwich, with Dr. Copeman as president elect.

—

*The Cost of Hospital Buildings.*—The cost of the site for the new St. Thomas's Hospital, London, we learn from the *Lancet*, July 26, 1873, is £148,545. The total cost of the building is £383,948; that of the furniture upwards of £10,000; the total outlay being upwards of £552,000. The cost per bed is a little more than £530, with a cubic capacity of 1800 feet for each patient.

The Herbert Hospital—one of the best constructed pavilion hospitals in Europe—with a cubic capacity of 1200 feet per head, cost £320 per bed. The Lariboisière Hospital, at Paris, with a cubic capacity of nearly 1900 feet per patient, is said to have cost £440 per bed; and the expense of the Hôtel-Dieu, at Paris, now in course of erection, with a cubic capacity of 2300 feet per head, is reported to be £750 per bed if intended for 800, or as much as £1500 per bed if the number of these be reduced, as proposed, by half. Taking, therefore, the average cost of these great hospitals, the average cost per bed will be a little over £500, and the average cubic capacity 1800 feet.

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*Adhesive Plaster.*—According to Otto Facilides, adhesive plaster, which has become brittle by age, and has lost its adhesive qualities, may be rendered adhesive again by coating it with oil of turpentine, by means of a sponge, and leaving it exposed for a day.—*Am. Practitioner.*

—

*M. Littré.*—We regret to learn that M. Littré, the distinguished lexicographer, is suffering from carbuncle of the chest, and, owing to his advanced age, his medical attendants are anxious as to the result.

## NOW READY.

### THOMPSON ON THE PROSTATE.

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Is likely to be extremely useful to all students, who, in taking cases, must necessarily follow a similar, if not exactly the same, mode. Nor is it only to the student that this book is likely to be of use; many practitioners will find their diagnosis all the more clear, and their ideas of the nature of their patient's illness probably much more definite, from a little attention to the logical mode of inquiry laid down in it.—*Edinburgh Medical Journal*, July, 1873.

These two extracts will give the reader a good idea of the nature of this book, and he will be ready to confess that there is really a place for just such a work. It is a book for the young practitioner, full of good instructions about making a diagnosis on little points not mentioned in regular text-books.—*Cincinnati Clinic*, Aug. 9th, 1873.

This book fills a gap in our medical text-books. We earnestly commend it to the careful study of second course students, and young practitioners.—*Detroit Rev. Med. and Pharm.*, Aug. 1873.

Quite suggestive, and a valuable help to the student as a preliminary study.—*N. Y. Medical Journal*, Aug. 1873.

## SHORTLY.

### FENWICK'S DIAGNOSIS.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on Two Cases of Death after Holt's Operation.* By R. W. TIBBITS, M.B., M.R.C.S., Surgeon to the Bristol Royal Infirmary, Lecturer on Surgery at the Bristol Medical School.

GENTLEMEN: Those of you who take an interest in the treatment of stricture of the urethra are certain to read Mr. Barnard Holt's very interesting work upon this subject. You will see that he sums up the great advantages to be derived from his method of forcible dilatation or rupture in the proposition—"that the process is facile, speedy, prompt in its effects, and free from every danger—immediate or remote." I am afraid that the two cases I intend to bring under your notice this morning must throw considerable doubt upon the absolute correctness of the latter part of this proposition, or at least show that this rule is not without an exception.

The first case was that of a healthy-looking sailor, aged 25, who was admitted into No. 11 ward on February 21. Five years ago he had been laid up with a sharp attack of gonorrhœa, and since then had suffered from a gradually increasing stricture. Several unsuccessful attempts had been made by medical men to pass instruments into his bladder; after each attempt he had shivered and felt unwell for one or two days. He was kept in bed for three days, the bowels freely opened with castor oil, and on the evening of February 24 a full dose of Dover's powder was administered.

*February* 25. Holt's instrument was easily passed, and the stricture—a slight

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one—split with the largest-sized dilator. Afterwards No. 11 catheter was introduced into the bladder.

26*th*. Patient seemed perfectly well. Had not shivered after the operation, and passed his urine in a full stream, with slight pain.

27*th*. Still going on well. No. 10 catheter passed easily, causing little pain.

28*th*. Twenty-two hours after the passing of No. 10 catheter, and seventy hours after the operation, he was suddenly seized with a severe rigor, which lasted for two hours. He then perspired freely. Countenance extremely anxious-looking. Complained of much pain in his head and back. No tenderness in the perineum or over the abdomen. No albumen or pus in the urine. Nothing to be detected with the stethoscope. Pulse 120; temperature 101.6°.

*March* 1. Complained of feeling very ill. No recurrence of the rigor. No pain anywhere. Tongue dry and brown. Morning: Pulse 136; temperature 105°. Evening: Pulse 128; temperature 108.6°.

2*d*. Evidently much worse. Complained of no pain or tenderness anywhere. Urine scanty, but free from albumen. Nothing to be detected with the stethoscope. Morning: Pulse 136; temperature 104.2°. Evening: Pulse 116; temperature 104°.

3*d*. Perspiring freely. Could not be roused sufficiently to understand the questions asked him. Extremities congested. A dark purple petechial-looking rash had appeared over the whole of the body, especially on the chest, where it was very thickly distributed. Tongue dry and brown. Pulse 160; temperature 104.5°.

From this time he gradually passed into a state of coma, and died on the following night at a quarter-past one o'clock, the temperature rising to 107.6° fifteen minutes before death.

*Post-mortem Examination* (thirty hours after death).—Lungs congested posteriorly; extreme staining of inside of heart and bloodvessels; liver healthy; spleen enlarged, and broke down into a pulp when cut; kidneys presented numerous hemorrhagic spots, varying in size between a pin's head and a small pea—many of these showed signs of softening in their centre; bladder healthy, walls rather hypertrophied. Around the seat of stricture, at the junction of the spongy and membranous portions of the urethra, there was a slight extravasation of blood; the mucous membrane over this part was perfectly smooth—there was no apparent rupture of it. The prostatic veins were considerably obstructed, and one of them was blocked with a firm clot for about an inch and a half.

This, gentlemen, is one case. Let me now briefly read you the notes of the second one, which appeared in our post-mortem room yesterday, and which you have all had an opportunity of observing:—

D S., aged 46, a muscular Irishman, was admitted into No. 9 ward on December 13. He told us that he had only noticed that his urine came in a small stream during the last two years; that on several occasions he had had small sized instruments passed, and that once or twice he had shivered after their passage, but this was not the rule.

*December* 14. A No. 5 sound was attempted to be passed, but only for a short time, as the stricture bled at the slightest touch of the instrument.

15*th*. Had suffered no inconvenience from the attempted passage of the sound. Ordered ten grains of Dover's powder at night and half an ounce of castor oil the next morning.

16*th*. Holt's instrument was passed with little difficulty through a stricture in the membranous part of the urethra, which was split with the largest-sized dilator; one or two drops of blood following the operation. Ordered thirty minims of tr. opii and two ounces of brandy to be taken in hot water. In the evening he passed his water freely with little pain.

17*th*. 4 A. M.: Whilst at the closet was seized with a severe rigor, which lasted for about two hours. 9 A. M.: Temperature 102.2°; pulse 120. Ordered brandy and an opiate draught. 12 noon: Temperature 102°; pulse 130, weak; extremities cold and congested. Ordered five grains of carbonate of am-

monia every two hours. 2 P. M.: Pulse weaker. Ordered three ounces of brandy in hot water. 5 P. M.: In much the same condition. Brandy to be repeated. 9 P.M.: Temperature 100.2°; pulse 130. Brandy and ammonia to be continued: hot-water bottles to be applied to extremities.

18*th*. 9 A. M.: Temperature 100°: pulse uncountable. To continue brandy. 2 P. M.: Temperature 101.2°; pulse imperceptible at wrist; extremities mottled purple. Has passed no water during the last twenty-four hours; bladder not distended. Patient perfectly sensible, but restless. Ammonia to be discontinued; half an ounce of brandy every fifteen minutes; to be dry-cupped over loins and to have hot fomentations of infusion of digitalis applied over the abdomen.

From this time his condition changed but little. He passed a small quantity of water at about 6 P. M., and remained sensible to within a short period of his death, which occurred at 3 A. M. on the following morning—sixty-two hours after the operation, and forty-eight after the first rigor.

*Post-mortem Examination* (ten hours after death) —Moderately firm old pleuritic adhesions on both sides of the chest; lungs healthy, but congested at bases; heart and its valves healthy—a small quantity of clot and fluid blood in each cavity—no clot in the pulmonary artery; intestines and peritoneum healthy; liver to some extent congested, otherwise perfectly healthy; spleen healthy; kidneys healthy, not even congested. The bladder contained about six ounces of urine; walls slightly hypertrophied; mucous membrane healthy, and not congested, except for a patch about the size of sixpence at the posterior part of the neck of the bladder; the tissues under this were also congested for the depth of about the eighth of an inch. The urethra was slightly congested along its whole tract, and at the juncture of the spongy and membranous portions there was a patch of deep congestion, showing the seat of the stricture. There was slight extravasation of blood into the tissues around this for the depth of about the eighth of an inch. The mucous membrane over this point, examined under the microscope with a two-inch lens, showed no sign of rupture.

It has seldom been my duty to draw your attention to cases of so painful an interest as the two I have just related. Those of you who saw the first patient will recollect what a fine healthy-looking man he was. You will also remember, that in the operation-room I mentioned that it was the slightest case of stricture that I had ever performed forcible dilatation upon. It may be said that in this instance the passage of the catheter on the second day after the operation was the cause of the mischief; but then the subsequent passing of a catheter follows as a necessity upon this method of treatment. In the second case no such question can arise. This man, with all the organs of his body healthy, died in sixty-two hours from the undoubted effects of the operation.

There was a certain amount of resemblance between these two cases. In each the first symptom was a severe rigor, coming on many hours after the operation, and in each there was the same dusky congested appearance of the extremities. Very little either was there to be detected during life, and still less in the post-mortem examinations; for I look upon it as probable that the deeper red condition of the inside of the heart and large vessels in the first case was due to a considerable extent to the effects of decomposition. But the hemorrhagic spots in the kidneys of the first patient were exactly similar in appearance to that which you sometimes see in well-marked pyæmia. Moreover, during life, the symptoms and appearance of these patients closely resembled what we see in the worst cases of septicæmia, following after other operations or injuries which sometimes, but fortunately very rarely, occur in the wards of our Infirmary. Therefore I should put down the cause of death in both instances to blood-poisoning.

The practical lesson I wish you to learn is, that in performing any operation upon the urethra you cannot be too careful.

When the patient's history points to the stricture being a bad one, or more especially should he habitually have suffered from rigors after the passing or attempted passing of an instrument, let me urge upon you the advisability of insisting upon at least twenty-four hours' complete rest before you attempt to do anything. It has always been my rule to do this; and for two reasons—first, you will find it much easier to pass an instrument through a bad stricture if your patient has been kept quiet for some time; secondly, I believe that previous rest often obviates the occurrence of subsequent unpleasant symptoms, for I have more than once found that patients who had always suffered inconvenience from the passage of an instrument would stand considerable manipulation with impunity, previous rest having been insisted upon. At any rate, should mischief result, you will have the satisfaction of knowing that all rational means had been taken to prevent it. Holt's operation is one you have seen me perform moderately frequently, but never without having kept the patient in bed for at least forty-eight hours.

Mr. Holt claims for his operation that cases of stricture treated by this method show less tendency to contract than after any other plan of treatment. My experience relates only to strictures situated in the neighbourhood of the membranous part of the urethra; but it is decidedly in favour of this assertion. At the same time, as a rule, unless a full-sized instrument is afterwards passed with tolerable regularity, you are running your patient to unnecessary risk; for to a certainty will the diseased tissues again contract.

There is one more point of very special interest that these cases help to demonstrate. I mean what actually occurs when you rapidly force the dilator through the stricture. Mr. Holt advances the proposition that the diseased submucous tissue is alone split, and that the mucous membrane is simply dilated. This is a matter of considerable importance, because, with any considerable wound of the mucous membrane of the urethra, there would be a risk of infiltration of urine being the result, though I believe this risk would be slight. We particularly examined both these cases, with the view of obtaining information on this point, and undoubtedly they go towards proving the correctness of Mr. Holt's supposition; but we must bear in mind, that during the time these patients lived after the operation, a certain amount of rupture might have healed. Still, they certainly seem to prove that, at any rate when the stricture is not a bad one, the injury, if any, that is done to the mucous membrane is of the slightest.

With these two cases before us, it may perhaps suggest itself to the minds of some of you to ask—Why continue to perform the operation? You cannot learn too early that cases of stricture, as a class, are some of the most troublesome and difficult that you will have to deal with, and also that no method of treatment is perfectly free from danger, for death has more than once resulted from the simple passing of a catheter. There are also persons who will not submit to the tedious treatment by gradual dilatation. Specially have I found this amongst the lower classes, with whom time is of importance. These people will remain under treatment till the stricture is partially relieved, and then cease to attend, to come back again in a few months' time worse than ever. But even under these circumstances you would not be justified in performing Holt's operation, if the risk to life from it is considerable, unless the advantages to be derived from it are far more considerable. But what is the increased amount of risk? Sir H. Thompson, in his lectures on "Diseases of the Urinary Organs," lays no stress upon this point, neither is it referred to by many of our best surgical authorities. Moreover, the results published by Mr. Holt are extremely favourable; therefore we have a right to assume that the cases we have this morning considered are very exceptional. My experience of the advantages of the operation in successful cases is decidedly satisfactory; but unless the patient afterwards submits to the periodical passing of a full-sized instrument, the

stricture will again to a certainty contract, and the operation will have been useless.

In treating all ordinary cases of stricture let me advise you, as a rule, to adopt first of all the simplest method at your disposal, and fairly try the plan of gradual dilatation, reserving Holt's operation for the more severe cases, or for those patients who will not submit to lengthened treatment. Remember, also, that there are certain persons whose constitutions resent any interference with their urethra, and who will tell you that they nearly always suffer from a rigor after any attempt to pass a catheter. It will behoove you in such cases to be especially careful. —*Medical Times and Gazette*, August 2, 1873.

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### HOSPITAL NOTES AND GLEANINGS.

*Aneurism of Thoracic Aorta benefited by Large Doses of Iodide of Potassium.*—Under the care of Dr. Dyce Duckworth, at St. Bartholomew's Hospital, T. H., aged 47, a clerk, having served twenty-two years in the army, and twenty years of his time in India, applied in October, 1872, for relief from an aortic aneurism. He was first seen by Dr. Lauder Brunton. The patient was a stout well-built man, of florid complexion, with dark-brown hair; height, five feet six inches. There was no history of intemperance, or syphilis, or of bodily strain. Three years ago he first began to complain of pain across his chest, and had advice. He alleged that at that time there was a pulsating tumour, of the size of an egg, above and towards the left side of the sternum. It used to be visible to bystanders as moving his clothes. For six months he was under treatment, and the tumour reduced in size. He was able to resume his work, and has continued it since, with the exception of a few days. No further advice was sought, and no treatment employed, till October, 1872. At that time there were fulness and pulsation over the upper and left sternal region, with an area of dulness to percussion of one and a half by one and a half inches. There was a prolonged first sound over the cardiac region, no *bruit* being audible over the fulness. Pulsation was very feeble in the left carotid and brachial arteries. The left pupil was smaller than the right; the voice was hoarse. The treatment consisted of quinia till Christmas, 1872. At that time the cardiac sounds were more loudly heard over the tumour than over the præcordia, and there was a prolonged rough systolic blowing. The left pulse was much smaller than the right. The patient was able to act as a clerk, but suffered a good deal of pain in his chest and back, especially at night. At this time he was ordered ten grains of iodide of potassium three times a day, and morphia and chloral in a draught at bedtime each night. In January, the quantity of iodide was increased to fifteen grains for a dose. Under this treatment there was gradual improvement in all the symptoms. In April he was able to sleep without the anodyne, and he could take a fair amount of exercise daily. In May, he reported that his voice was at times natural, and that occasionally his pulse was fuller in the left wrist. He had no pain in the chest, slept well, and was doing duty as a storekeeper. The left pupil remained small; the pulse was hardly felt in the left radial artery; there was dulness on percussion for about two inches square in the region of the tumour to the left of the manubrium, and under the left clavicle. There was slight heaving pulsation over the area of the tumour; a very faint distant murmur, systolic, and of low pitch, was audible over the dull region; no dulness and no murmur was detected posteriorly. The patient continues to take iodide of potassium regularly.

*Remarks by Dr. Dyce Duckworth.*—The points of interest in this case are the following: The first is, the occurrence of aneurism in a soldier who had served long in India, and had, therefore, been subjected to the strain placed upon his circulatory system by improper clothing in that climate. (Thanks to the labours of Parkes and others, this is no longer the case in the British army.) The case is one of a class in which the course of the aneurism is very chronic. The aneurism illustrates a point which is not unfrequently to be

observed, but which is rarely commented upon, viz., the tendency of sacculated aneurisms to change their relation to surrounding parts. In the history of some of these tumours it is found that certain portions are more prominent at one period than at another. This is especially to be observed in such thoracic aneurisms as point through the chest-wall; hence the pressure-signs may vary from time to time. These changes are probably due to the peculiar depositions of fibrin upon the walls of the tumour. When this patient was first seen, there was no prominent pulsating swelling, such as he described to have existed about three years previously.

The marked benefit resulting from the iodide of potassium, when compared with the treatment by quinia, could escape the attention neither of patient nor of physician; and this case illustrates the good results of that plan of therapeutics, which was first recommended by Dr. Chuckerbutty, of Calcutta, and Dr. G. W. Balfour, of Edinburgh. In the case above described, no special precautions were enjoined, either as to diet or the recumbent posture; and Dr. Balfour's system of treatment includes a restricted allowance of food and rest. We have no knowledge as to the nature of the changes wrought in such a case by the iodide of potassium. It is not known to induce coagulation of fibrin; indeed, one would naturally regard the drug as one likely to diminish any tendency to hyperinosis. Dr. Arthur Gamgee has suggested that the good results are due to an action exerted upon the vaso-motor nervous system; and he believes that the present condition of blood-chemistry throws no light upon the subject.—*Brit. Med. Journal*, Aug. 28, 1873.

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*Treatment of Aortic Aneurism by Galvano-puncture.* — At University College Hospital on Tuesday, Mr. Marcus Beck operated by galvano-puncture on a very rapidly growing aneurism of the descending aorta. The patient, a man aged about 40, had only suffered from pain and dyspnœa about a month, and a pulsating tumour had appeared in the lower dorsal region a few days only before admission. During the short time the patient had been in the hospital, the tumour had been daily increasing in size, the neighbouring ribs becoming rapidly eroded. Mr. Beck introduced the wires about an inch apart through the most prominent part of the tumour, and passed the current between them for an hour and a quarter. The immediate effects of the operation were decidedly encouraging. The pain was much diminished, and the expanding impulse also lessened. The improvement still continued this (Thursday) morning. There was rather less bulging of the lower part of the chest, as well as diminished thrill. We shall report the further progress of the case next week.—*Brit. Med. Journ.*, Sept. 6, 1873.

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*Senile Gangrene of the Foot cured by the Oxygen Bath.*—Hôpital la Pitié. Under the care of Dr. Leon Labbe. This case is eminently illustrative of the good effects of the oxygen bath in cases of senile gangrene. The patient was a man of about fifty. The case began with atrocious pain in the toes of the left foot, and the large toe and the next one soon assumed a dark-red colour, the patches extending in small ribbon-like lines to the articulation of the foot and leg. It was impossible to mistake the beneficial effects of the application of oxygen—the symptoms were almost instantaneously amended. The pain ceased immediately. On removing the oxygen, experimentally, the pain returned, and the other symptoms got worse. An eschar, formed on the large toe, has now fallen, and all that is at present left of the disease is a slight pinkish hue of the two toes, extending a little up the foot.—*Lancet*, Aug. 2, 1873.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Circumcision for Congenital Phimosis with the Galvanic Cautery.*—In order to avoid the possibility of dangerous hemorrhage following the ordinary operation of circumcision, F. Dawson (*Am. Journ. of Obstet.*, Aug. 1873) determined to make use of the galvanic cautery in a case

brought to him for operation. He noosed the prepuce in a loop of fine platinum wire connected with his battery, and then removed it by constriction, after which two or three strips of the mucous membrane with scissors enabled him to retract and liberate the glans. The results of the case satisfactorily demonstrated the success of this mode of operating, which, in Dr. Dawson's opinion, commends itself for trial in other cases.

Dr. Dawson claims the following advantages for this method: Entire avoidance of immediate or secondary hemorrhage; quickness of the operation over other methods, for when the wire is fully heated, the removal of the prepuce should be but momentary; avoidance of the necessity of restraining the patient as to exercise, etc.

In his next case Dr. Dawson intends to operate with the cautery knife instead of the loop.

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*Morphia in Acute Uræmia.*—Dr. Alfred L. Loomis (*Medical Record*, Aug. 1, 1873), in a recent paper on acute uræmia, discusses the propriety of administering morphia in full doses hypodermically to patients with acute uræmia, and the effects which follow such administration. The histories of ten cases which he narrates, lead him to the following conclusions:—

*First.* That morphia can be administered hypodermically to some if not to all patients with acute uræmia, without endangering life.

*Second.* That the almost uniform effect of morphia so administered is—1st, to arrest muscular spasms by counteracting the effect of the uræmic poison on the nerve-centres; 2d, to establish profuse diaphoresis; 3d, to facilitate the action of cathartics and diuretics, especially the diuretic action of digitalis.

Thus morphia, administered hypodermically, becomes a powerful eliminating agent.

The rules which are to govern its administration are as yet not well defined. My own experience would teach me to give small doses at first—not to exceed ten minims. If convulsions threaten, and a small dose does not arrest the muscular spasms, it may be increased to twenty minims, and the hypodermics may be repeated as often as every two hours. It must be given in sufficient quantities to control convulsions; neither the contraction of the pupils nor the number of the respirations is a reliable guide in its administration.

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*Hypodermic Injections of Morphia in Autumnal Catarrh.*—Dr. Carson, of Cincinnati, at a late meeting of the Cincinnati Academy of Medicine, stated (*The Clinic*, Sept. 20, 1873), that in a case of hay fever he had adopted the suggestion of Dr. Moss, of Philadelphia (*Am. Journ. of Med. Sci.*, Jan. 1873, p. 275), and gave the sulphate of morphia, gr. one-fifth, hypodermically. The symptoms were absent for three days, and then returned. He again repeated the operation with the same results, but the cough still continued. In this case the eyes were swollen and red, the membranes of the nose congested, and violent sneezing was almost constant. He again administered the hypodermic injection of morphia with relief. He suggested a trial of this agent in these cases.

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*Rules for Feeding Babies.*—The following rules are extracted from an essay recently read before the Public Health Association, by Dr. A. Jacobi, of New York:—

I. *Nursing Babies.*—Overfeeding does more harm than anything else. Nurse a baby of a month or two every two or three hours. Nurse a baby, of six months and over, five times in twenty-four hours, and no more. When a baby gets thirsty in in the mean time, give it a drink of water, or barley-water. *No sugar.* In hot weather—but in the hottest days only—mix a few drops of whiskey with either water or food, the whiskey not to exceed a teaspoonful in twenty-four hours.

II. *Feeding Babies.*—Boil a teaspoonful of powdered barley (grind it in a coffee grinder) and a gill of water, with a little salt, for fifteen minutes; strain it and mix it with half as much boiled milk, and a lump of white sugar. Give it lukewarm, through a nursing bottle. Keep bottle and mouth-piece in a bowl of water when

not in use. Babies of five and six months, half barley-water and half boiled milk, with salt and white sugar. Older babies more milk in proportion. When babies are very costive, use oatmeal instead of barley. Cook and strain. When your breast-milk is half enough, change off between breast-milk and food. In hot summer weather try the food with a small strip of blue litmus-paper. If the blue paper turns red, either make a fresh mess or add a small pinch of baking soda to the food. Infants of six months may have beef-tea or beef soup once a day, by itself, or mixed with other food. Babies of ten or twelve months may have a crust of bread and a piece of rare beef to suck. No child under two years ought to eat at your table. Give no candies, in fact nothing that is not contained in these rules, without a doctor's order.

III. *Summer Complaint.*—It comes from over-feeding and hot and foul air; never from teething. Keep doors and windows open; wash your children with cold water at least twice a day, and oftener in the very hot season. When babies vomit and purge, give nothing to eat or drink for four or six hours, but all the fresh air you can. After that time you give a few drops of whiskey in a teaspoonful of ice-water every ten minutes, but not more until the doctor comes. When there is vomiting and purging give no milk. Give no laudanum, no paregoric, no soothing syrup, no teas.—*Medical Record*, Sept. 15, 1873.

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*A National University.*—At a meeting of the National Educational Association, held at Elmira on the 5th, 6th, and 7th of August last, President ELIOT, of Harvard University, read a sensible and conclusive paper on this subject. "After detailing at considerable length the history of the action of the association on this subject in 1869, he proceeded to examine the two bills which were brought before Congress in 1872 and to discuss the true policy of the government upon this matter. Under the first head it was shown that although the association had from time to time appointed committees to consider the subject, yet it had never committed itself to any definite policy, and the bills introduced into Congress for the establishment of such a university had been almost solely the work of individuals, and without authoritative support. Passing to consider the bills introduced for the creation of a university, they are found to be crude in conception, cumbrous in the provision of the machinery of administration, and impracticable of execution. But even if these essential defects could be remedied, it is no part of the duty of government to maintain a magnificent university. 'The general notion that a beneficent government should provide and control an elaborate organization for teaching, just as it maintains an army, a navy, or a post-office, is of European origin, being a legitimate corollary to the theory of government by divine right.' But the arguments in support of this view prove a great deal too much. For if they have the least tendency to persuade us that government should direct any part of secular education, with how much greater force do they apply to the conduct by government of the religious education of the people. There is one broad reason why government should not establish and maintain a university. If the people of the United States have any special destiny and peculiar function in the world, it is to try to work out under extraordinarily favourable circumstances the problem of free institutions for a heterogenous rich, multitudinous population, spread over a vast territory. We indeed want to breed scholars, artists, poets, historians, novelists, engineers, physicians, jurists, theologians, and orators; but first of all we want to breed a race of independent, self-reliant freemen, capable of helping, guiding, and governing themselves. Now the habit of being helped by government, even if it be to things good in themselves—to churches, universities, and railroads—is a most insidious and irresistible enemy of republicanism, for the essence of republicanism is self-reliance.—*The College Courant*, August 16, 1873.

## FOREIGN INTELLIGENCE.

*Treatment of Wounds.*—Mr. John Wood, in his Address in Surgery delivered before the British Medical Association at its recent meeting said, "that after frequent trials, I have come to consider that a plan comprising the free use of Chassaignac's drainage tubes passing from the surface of the wound, or from its interior if deep and sinuous, and with their outer extremities imbedded in cotton wool or oakum, well permeated with MacDougall's or Calvert's powder, or other disinfectant and absorbent of discharges; the surface of the wound washed over after bleeding has ceased with a mixture of solutions of chloride of zinc and carbolic acid or sulpho-carbolate of zinc; the same solution to saturate the lint, applied in the same way as in water dressing, and enveloped in thin gutta-percha tissue, the whole supported by strapping and a light bandage, affords the readiest, lightest, coolest, and the most generally useful application of the antiseptic method. An outer envelope of cotton wool or oakum, and dressing every day after the first opening of the primary dressing, complete a method from which I have obtained as good results as from any other that I have tried, and, what is perhaps important, I have found it less difficult to insure its being properly carried out.

"I believe that cases of recovery frequently occur under other methods, or no methods, and that at least as much depends upon the age and reparative power of the patient, the amount of blood poison formed or absorbed, and the general conditions of the atmosphere as upon any system of treatment whatever.

"I attach much importance, as I have said, to free drainage in dressing wounds, and when these are made by the surgeon a good deal more may be done to favour this by a judicious choice of the direction of the incision in resections, etc., and the position of the flaps, etc., in amputations. The plan of making a puncture in the popliteal space, proposed by Mr. Jonathan Hutchinson in excision of the knee-joint, is one which illustrates my meaning. The wound should if possible be made to slope towards that part which is most dependent when the patient is laid in bed. In amputations of the thigh, I think for this reason that the circular operation is most objectionable, on account of its forming a hollow funnel-shaped wound, which, in the necessarily raised position of the stump upon a pillow, holds the discharge like a bucket slightly tilted. Very good drainage is accomplished in the late Mr. Teale's excellent plan of a single square anterior flap. I have practised Mr. Teale's method with the best results in the leg and forearm; but for other reasons, I prefer in the thigh an oblique double flap, with the outer end of the incision placed lower than the inner, and the front flap placed somewhat outside the limb, and longer than the hinder. After many trials, I am quite convinced that this both gives the most complete drainage, prevents the bone protruding, and makes a very shapely and serviceable stump, with the cicatrix placed well behind the point of pressure. Another important point bearing on this matter in favouring the escape of discharges from the interior of a wound, lies in the manner of securing the arteries. When an artery is twisted in, as in the ancient Roman system, revived by Amussat and Velpeau, and lately tried by Mr. Cooper Forster[1] and Mr. Bryant,[2] or when it is secured by a pin or wire, as advocated by the late Sir James Simpson, and practised at Aberdeen and elsewhere; or when it is secured by an antiseptic catgut ligature, cut off short on the vessel, as revived by Professor Lister, and tested by Mr. T. Holmes, the theory is, that the wound should heal in the deeper parts as well as in the more superficial, by the direct adhesive process. But this, in the amputation of an extremity, or a large resection, is not the rule, and moreover, in large cities is not usual. Now the parts that are most disposed so to heal are the smoothly cut, self-adapting and vascular tegumentary structures, and these sometimes close up by adhesion, leaving interior cavities, especially about the bone, and between the muscles,

1 Trans. Clinical Society, 1870.

2 On the Torsion of Arteries, Medico-Chirurgical Transactions, li. p. 199.

containing decomposing blood or pus, which afterwards accumulate, burrow, give trouble, and delay the cure, or cause by pyæmia the death of the patient. To prevent this subsequent inconvenience, after experience of it, seems to be the only rational explanation of the continental method still employed of stuffing the whole wound with charpie, so as to insure healing from the bottom, which seems so strange to our notions. If we could be quite sure that by torsion, metallic or antiseptic ligatures, we could secure complete adhesion throughout, the case would be made very much stronger in their favour. But this is certainly the exception, and not the rule. There are other elements at work influencing this, even more powerful than the local treatment. Now I believe with my colleague, Sir W. Fergusson, that so long as we have this want of entire union, ligature threads may have the advantage of keeping open channels for the escape of discharges from the close neighbourhood of the tied arteries, the accompanying veins of which are frequently the sources of effusions of blood after the wound is dressed, and these afterwards clot, and may putrefy. The ligature threads I usually have well steeped in carbolized oil, and saturated so as to be unable to absorb discharges, and so utilized to spread around an antiseptic influence. Sometimes in deep narrow wounds I place them within or alongside of a drainage tube. They can thus be made into channels for the introduction of antiseptic agents to the deeper parts, and this consideration may add to the much greater sense of security given to the surgeon's mind on leaving his patient, arising from the use of a safe knot and a string to remove it by when it has performed its work. There is one point in the section of flaps which may I think have influence sometimes upon the introduction of pus or septic matter into the cut veins. When these are cut obliquely with the face of the flap, they are opened in a large conic section in the shape of a pen, and left, when placed on the underlying flap, in an attitude well adapted for receiving and conducting into their interior pus and putrid discharges which gravitate from the surrounding hollow and often funnel-shaped sides. To obviate this, I invariably, after a flap amputation, cut off the larger veins transversely."—*Brit. Med. Journal*, Aug. 9, 1873.

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*Injection of Iodine during Acute Inflammation.*—Dr. Menzel, Senior Surgeon to the Trieste Civil Hospital, has published an article in the *Gazetta Medica Lombardia* of July 19, on "The Injection of Iodine into Tissues the seat of Acute Inflammation." He observes, that while during the last ten years various articles have been injected into the substance of tissues affected with different forms of chronic disease, he is not aware of any instances in which such practice has been pursued during the existence of acute inflammation. Repugnance has been felt to injecting tissue, the seat of acute phlogosis, with substances possessing more or less power of inducing inflammatory action. His object in the present paper is to show that such practice may nevertheless be attended with great benefit; and, although he certainly is able to adduce but very slight evidence in favour of this view, we may as well lay it before our readers. During last spring diphtheria prevailed severely in Trieste, defying the various remedies employed, such as cauterization, the chlorate and permanganate of potash, carbolic acid, quinia, etc. Most of the children brought to the hospital were already affected with excessive bilateral tumefaction of the cervical glands, the lymphadenitis pursuing a rapid course in diphtheria, and inducing a far greater amount of swelling than is observed in ordinary catarrhal tonsillitis. In the author's opinion, the frequent inefficiency of caustics arises from the circumstance that the morbific agent has been transported from the parts accessible to their action (as the tonsils, velum, etc.) to the glands of the neck, and thence into the circulation. Under such circumstances the caustics will only act by limiting the local gangrene; and, although the tonsils may be freed, the ganglionary intumescence and the general symptoms persist, and the patients succumb. The question arose whether the "parenchymatous injection"

of iodine might not arrest the local destructive process, and at the same time, by its absorption, exert a favourable effect on the progress of the disease. The first case in which it was tried seemed to realize the most sanguine expectations. A girl, aged 6, when brought in, had been ill two days, and the tonsils were so swollen as to be in intimate contact with each other. The removal of the white membrane which covered them exposed an ulcerated surface. Beneath the angle of the jaw on each side were two or three glands the size of walnuts, of an elastic consistency, and very tender to the touch. Each tonsil, by means of a Pravaz syringe, was injected with four drops of Lugol's solution. Next day the tonsils were found reduced to their normal dimensions, and the glandular swellings were hardly perceptible. In other cases the iodine was injected in part into the tonsil and in part into the arch of the palate and the velum, and was repeated daily until the tonsils were reduced. Of seven children so treated three recovered; and although two died, and the other two, not being heard of again, probably also died, yet, as the epidemic was a very severe one, even this amount of success is not to be despised. Dr. Menzel, however, admits, that he has not brought much material forward, but he observes that the means are quite innocuous, and are productive of no local inconvenience.—*Med. Times and Gaz.*, Aug. 2, 1873.

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*On a New Method of Determining the Presence of, and Recovery from, True Ringworm.*—At the recent meeting of the British Medical Association, Dr. Dyce Duckworth called attention to the action of chloroform upon the infected hairs in cases of tinea tonsurans. It was shown that this agent caused the hairs to become white or slightly yellow in colour, and thus to be distinctly mapped out and easily distinguishable from surrounding healthy hairs. The causes of the change were briefly discussed, and the particular phases of the disorder suitable for this application were pointed out. The effect of chloroform on patches of favus, tinea versicolor, melasma, and alopecia areata was likewise discussed. It was shown that no other reagent, so far as was known, possessed the peculiar properties of chloroform in affecting parasitically diseased hairs.—*Brit. Med. Journ.*, Aug. 30, 1873.

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*Disease of the Heart from Over-exertion.*—There are few more interesting subjects in cardiac pathology than the so-called "spontaneous" enlargement of the heart. Many authors have gone so far as to deny *in toto* the occurrence of uncomplicated hypertrophy or dilatation of the heart or of one of its ventricles; but their position has now for some time been untenable as was especially pointed out by Dr. Quain in his recent lectures on "Diseases of the Muscular Walls of the Heart." We have now before us a contribution of no less than nineteen cases of the kind, observed by Frantzel in soldiers who had taken part in the Franco-Prussian war (Virchow's *Archiv*, 1873, vol. lvii. p. 215, and *Centralblatt*, 1873, No. 35). These patients were perfectly healthy at the commencement of the campaign, and began to suffer from cardiac symptoms for the first time during the course of the war. When they came under treatment at the end of the campaign they were found to be labouring under enlargement of the heart, without discoverable disease in any other part of the vascular system, in the lungs, or in the kidneys. Of the cases enumerated the left ventricle alone was hypertrophied and dilated in ten, the right ventricle alone in two, and both ventricles in three; and in two other cases dilatation alone of the one ventricle or the other was found. Frantzel accounts for the cardiac enlargement by the extreme fatigue and muscular exertion which the men underwent for months in the field. The increased pulmonary activity induced by the obstruction to the expansion of the thorax under the uniform raised the tension in the pulmonary artery, and caused dilatation with hypertrophy of the right ventricle; and in the same way a corresponding enlargement of the left ventricle was brought about by the severe muscular exertion generally, as well as by the contraction of the peripheral arteries during the cold of

winter. The occurrence of simple dilatation is accounted for by the extreme severity of the exertion in some cases, and by the proportionately less resistant power of the cardiac tissue in others, who were badly nourished under the circumstances of privation in which their disease commenced.—*Med. Times and Gaz.*, September 6, 1873.

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*Syphilitic Meningitis rapidly cured by Iodide of Potassium.*—The symptoms were as follows: Persistent cephalalgia, contraction of the muscles of the nape of the neck, dilatation of pupils, alternate redness and paleness of the face, slowness of speech, groaning, contraction of limbs, vomiting, etc.; pulse 88 to 92; temperature normal. On the eighth day, a treatment, consisting of mercurial frictions, and from a half to one drachm of iodide of potassium internally, was begun, and then the latter remedy alone was employed; the amendment was most rapid after three days. The use of the iodide was suspended, as a trial, and the headache returned, but resumption of the remedy again removed it, and at the end of eight days the patient (a syphilitic woman), left the hospital entirely recovered.—*Lancet*, Aug. 2, 1873, from *Ann de Dermatologie et de Syphiligraphie.*

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*Cases illustrating the Endemic and Non-infectious Character of Diphtheria.*—Dr. W. Carr read a paper on this subject at the recent meeting of the British Medical Association.

The object of his paper was to support the following inferences: 1. When diphtheria breaks out in a family, attacking one or more of its members, the cause will be found in some local sanitary defect. 2. The family should at once remove from the infected house—a measure at once obligatory and preventive. 3. Imported diphtheria does not, as interpreted by the cases, spread in a family. Comparing the well-known histories of the spreading, by importation, of scarlet fever, etc., with diphtheria, we are forced, resting our conclusions on the cases narrated in this paper, to accept the teaching that diphtheria is neither infectious nor contagious, but strictly a preventable endemic disease, whose extermination will be, in due time, one of the victories of sanitary science.—*Brit. Med. Journ.*, Sept. 6, 1873.

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*Hemorrhage of the Pericardium, consecutive on Hemorrhage of the Left Ventricle.*—The above case was recently communicated to the Anatomical Society of Paris by M. Dransart. It occurred in a woman of seventy, who, the very day of her death, seemed to enjoy perfect health. She had always been in good health. The results of the autopsy were briefly as follows: Pericardium distended by liquid blood; external aspect of large blood-vessels healthy; ecchymosis on the posterior wall of the heart, in the situation of the left ventricle; towards the centre of this ecchymosis there existed a very small aperture, admitting the end of a grooved sound, which penetrated thus into a cul-de-sac, extending obliquely into the thickness of the ventricular parietes; no alterations were found in the situation of the large bloodvessels on opening the cardiac cavities; not the slightest communication existed between the left ventricle and the pericardium; incisions made into the ecchymosis showed that the infiltration of blood extended deep into the ventricular walls, but a certain portion of the ventricular muscle, towards the endocardium, was free from infiltration; the muscle seemed quite healthy; heart of normal size; no notable deposit of fat. Marked lesions of the posterior coronary artery were discovered; the internal surface was intensely red; a reddish clot blocked up the artery; proceeding from the auriculo-ventricular artery there appeared a collateral branch, extending towards the seat of hemorrhage. This artery was whitish, deprived of blood, and no doubt had afforded the liquid which had brought on the hemorrhage. Doubtless there had been rupture of a little altered artery on collateral circulation being re-established after the obliteration of the posterior coronary artery. The anterior coronary was also altered, the walls being thickened, and the internal aspect being reddish; but it

was pervious. The case is interesting as showing the possibility of spontaneous and fatal pericardial hemorrhage, due to lesions of the coronary arteries, and independent of rupture of the heart or of the large vessels.—*Lancet*, Aug. 2, 1873.

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*Forcible Rectification of In-knee.*—M. Delore read a paper on this subject before the French Association for the Advancement of Science. In-knee is a common result of rickets and scrofula, which prevail so extensively at Lyons. M. Delore states it is principally due to exaggeration of the natural curvature of the femur and tibia, accompanied by great depression of the internal tuberosity. In 350 cases he has rectified it by forcible pressure under chloroform, continued until the periosteum is detached and the epiphysis is separated, as announced by a cracking sound. The position is maintained by a starch bandage, and in a month the cure is complete No accident has occurred, but the operation should not be performed after the fifteenth year or on weak subjects.—*Med. Times and Gaz.*, September 6, 1873.

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*Surgical Means for increasing the Growth of Bones.*—M. Ollier read a paper on this subject before the Section of Medical Sciences of the French Association for the advancement of Science. The paper was founded on a series of experiments and clinical observations. He finds that where there has been arrest of growth of the long bones, impeding progression or causing deformity, he can induce increase of growth by producing a superficial exfoliation of bone by means of caustics. In an instance in which, after an arrest of growth of the radius had been followed by deformity of the hand consequent on the continued growth of the ulna, this was rectified by the removal and crushing of the cartilage of the latter.—*Med. Times and Gaz.*, September 6, 1873.

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*Effects of Senna on the Urine.*—At the last meeting of the Paris Therapeutical Society, Professor Gubler drew attention to a curious property in senna of colouring the urine in a peculiar manner. The urine of persons who have taken senna becomes of an intense yellow colour with a green reflection, just like the urine in jaundice; but nitric acid shows that bile has nothing to do with this colouring. If a fragment of caustic potass be let fall to the bottom of a tube containing urine charged with senna, a magnificent purple colour is produced; but nothing of the sort takes place under the influence of potass in icteric urine. This colouring has been observed in all the patients who have taken senna whose urine has been examined—even where only half an ounce of the infusion or a black draught of the Codex has been administered. Urine loaded with senna is incapable of assuming the variable rose colour under the influence of nitric acid which normal urine always assumes. Infusion of senna itself treated with caustic potass assumes, to a certain extent, the purple colour. But the phenomenon is here far less marked, and M. Gubler believes that in this case a process goes on similar to that which occurs in relation to asparagus, turpentine, copaiba, etc.—a certain amount of oxidation taking place in the economy for the production of the peculiar odour of asparagus or the violet odour. With rhubarb M. Gubler produced a much less intense colour than with senna; but he suspects that the phenomenon in both cases is due to the chrysophanic acid, which is common to both the substances. After the absorption of the senna, the colouring of the urine may persist, even to the next day. M. Gubler observed that for the detection of bile in the urine he always employs nitric acid, which he thinks is far preferable to iodine. He referred also to a peculiar colour of the urine often met with in severe disease, furnishing a *feuilles mortes* colour, which may be easily mistaken for biliary colouring. The colour is really due to the superposition of a blue colour on the yellow; and at his clinic M. Gubler has often shown this blue colouring, which he has named provisionally "urinary *indigose*." On isolating it by ether, he renders the liquid clear by bringing to its upper part a ring of a beautiful blue colour.—*Med. Times and Gaz.*, Aug. 30, 1873.

*Action of Nitrous Oxide.*—Joylet and Blanche (*Archives de Phys.*, v. July, 1873, p. 364) have obtained the following results from their experiments on this subject. Chemically pure nitrous oxide will not support the respiration either of animals or plants, as they cannot decompose the gas. When breathed in a pure state by animals, it causes asphyxia and death, with all the symptoms usually occasioned either by strangulation or by the respiration of an inert gas, such as nitrogen or hydrogen. Nitrous oxide causes death in nearly the same time as these other asphyxiating agents. Nitrous oxide has no special anæsthetic action. The anæsthesia which it may produce when inhaled in a pure condition is only due to want of oxygen in the blood. Insensibility appears when the oxygen in arterial blood is reduced to less than 2 or 3 per cent. Arterial blood is then very dark, and contains 30 to 40 per cent. of nitrous oxide. Animals can live and show no alterations of sensibility while breathing mixtures of nitrous oxide and oxygen, in the same proportion as nitrogen and oxygen in air. The arterial blood then contains about 30 to 35 per cent. of nitrous oxide. Birds placed under a bell-jar filled with this mixture, behave exactly like those placed in a jar of the same size filled with air, and die after having exhausted the oxygen to a similar extent and formed a similar amount of carbonic acid. As nitrous oxide is an irrespirable gas and does not possess the anæsthetic properties which have been attributed to it, the authors conclude that its employment cannot but be dangerous, and ought, on this account, to be excluded from medical practice.—*Brit. Med. Journal*, Aug. 9, 1873.

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*Sugar and Magnesia an Antidote to Arsenic.*—The *Mouvement Médical* relates various experiments conducted by Mr. Carl, with the result of showing that sugar, mixed with magnesia, may serve as an antidote in cases of poisoning by arsenious acid, in which cases, too, the internal use of the hydrated magnesia is most valuable.—*Lancet*, August 2, 1873.

*Typhoid Fever and Milk.*—An outbreak of typhoid fever in London, a description of which will be found in *The American Journal of the Medical Sciences* for October, 1873, and which is now happily near its end, has drawn special attention to the propagation of enteric fever by means of milk. From *The London Medical Record* (Sept. 8, 1873) we learn that at Brighthouse near Halifax, and at Wolverhampton, epidemics have been traced to the milk-supply. At the former place, as many as fifty cases of the disease have occurred, although the exact manner in which the milk became contaminated is not very clear. At Wolverhampton the numbers affected have been limited; but the origin of the milk-adulteration was, it appears, not difficult to find, as the water-supply of the farm was obtained from a sewage-poisoned well.

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*Deaths from Chloroform.*—A lady died on August 20, at the house of a dentist in Brighton, while under the influence of chloroform. The necropsy disclosed fatty degeneration of the heart.

A death from chloroform is recorded in the last British Army Blue-Book by Surgeon J. L. Erskine, M.D., of the Royal Engineers. The patient was being operated upon for removal of diseased tibia, the result of compound fracture, and was not under the influence of chloroform above one minute, when the failure of the heart's action was noticed. The necropsy showed a hypertrophied heart and a flabby condition of its muscular walls.—*British Medical Journal*, August 23, 1873.

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*Propagation of Cholera.*—It is known that the Russian State authorities, with Pelikau at their head, differ considerably in their conclusions as to the recent outbreaks of cholera in that country and eastern Europe from those of most other nations. They concluded that these outbursts were not new importations, but were due to the seeds of the disorder having remained latent from former epidemics, even as far back as 1852. They have now sent to this country the evidence on which this opinion is founded—evidence which seems fairly irrefragable, and as a

consequence of which we are fain to confess that in all probability cholera is now fairly naturalized as an endemic malady in eastern Europe. We had already been compelled to assent to the statement that cholera had become naturalized in Persia, but we were hardly prepared for the same disquieting fact as regards Europe; but that being so, all information as to the mode in which it spreads assumes an increased importance, and we have seen nothing of greater importance on the subject than an abstract of modern views on the subject by Professor Parkes in the appendix to the recently-issued Army Medical Report.

This deals at some length with the views of Pettenkofer, as recently enunciated by him in a somewhat modified form, in reply to adverse criticisms from Sander and Küchenmeister. There is no denying their importance, not only from the weight of Pettenkofer's authority, but from the influence they exercise on the minds of many, both in this country and abroad. They have materially modified modern research in the matter, and should they turn out to be wrongly founded, this influence must have been most pernicious. The foundation of Pettenkofer's theory rests on the assumption that the cholera contagium is mainly or entirely propagated outside the human body; and thus the malady, from his point of view, though readily carried by human beings, and in the main following the lines of human intercourse, is not, strictly speaking, contagious, but rather miasmatic. The quantity of this contagious matter, according to his views, undoubtedly tends to increase, but it does so in the surroundings of the individual, not in himself; and the most important of these foci of new growth is the ground itself; and on peculiarities of soil he holds that the development of cholera mainly depends. He rejects *in toto* the theory of propagation by drinking-water, which he says in many instances he has investigated was impossible. Shipboard has been selected as a telling instance, where neither soil nor ground-water could be imported into the case, and has by some been considered utterly fatal to the ground theory of cholera. This Pettenkofer does not admit, and yet is compelled to acknowledge that cholera has broken out in ships in epidemic fashion, though it is most frequently brought from the shore. Here he tries to import some new factor into the case analogous to the ground on shore, but seems to fail. Direct contagion, without any interference on the part of the soil, seems to be only too well established, yet Pettenkofer rejects it entirely. Nevertheless, in all probability the ground has some influence, though what it is seems as yet not quite clear; nor does it seem to be exercised in all cases. It is always a misfortune if a man resolutely blinds himself to any side of a question save that on which he himself is intent.—*Medical Times and Gazette*, July 12, 1873.

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*The International Medical Congress.*—The third International Medical Congress will be held in Vienna, from September 1st to 8th, under the patronage of the Archduke Rainer, and the presidency of Professor Rokitansky. The members of the congress will consist of delegates from states and from scientific bodies, and of medical men and naturalists, who shall have intimated their intention of being present to the general secretary, before the opening of the meeting. Discussions are appointed to take place on the following subjects. 1. Vaccination: reporters, Dr. Hebra, Dr. Auspitz, and Dr. Kaposi. 2. The prophylaxis of Syphilis, with reference to the Regulation of Prostitution: reporters, Dr. von Sigmund, Dr. Reder, and Zeiss. 3. Quarantine, with special reference to Cholera: reporters, Dr. Oser, Dr. Drasche, and Dr. Witlacil. 4. The Sanitation of Towns (especially sewerage and drainage): reporters, Dr. Innhauser, Dr. Böhm, and Dr. Gauster. 5. The formation of an International *Pharmacopœia:* reporters, Dr. Bernatzik, Dr. von Schroff, sen., and Dr. von Schroff, jun. 6. The Social Position of Medical Practitioners: reporters, Dr. Schneller, Dr. Benedikt, and Dr. Schlesinger. The congress will be held in the Jury Pavilion of the International Exhibition at Vienna. The first meeting will take place on September 1st, at ten A. M.—*British Medical Journal*, Aug 23, 1873.

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Students of physiology for years past have found the manual of Kirkes and Paget a most excellent and reliable guide to that study. The handbook before us is simply the same work, in a new dress. Students and amateurs in physiology will find this not a mere elementary work, but a condensed work affording all the outlines of the science up to the present time.—*Cincinnati Lancet,* Sept. 1873.

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These two extracts will give the reader a good idea of the nature of this book, and he will be ready to confess that there is really a place for just such a work. It is a book for the young practitioner, full of good instructions about making a diagnosis on little points not mentioned in regular text-books.—*Cincinnati Clinic,* Aug. 9th, 1873.

This book fills a gap in our medical text-books. We earnestly commend it to the careful study of second course students, and young practitioners. —*Detroit Rev. Med. and Pharm.*, Aug. 1873.

Quite suggestive, and a valuable help to the student as a preliminary study.—*N. Y. Medical Journal,* Aug. 1873.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on a Case of Paralysis of the Diaphragm.* By C. HANDFIELD JONES, M.B. Cantab., F.R.S., Physician to St. Mary's Hospital, London.

*Case.*—E. H., aged 30, servant, was admitted January 14, 1873. He had dark hair, and was of medium height, fairly well made. He had been ill, off and on, seven or eight years. When admitted, he had been ailing two months. He was very subject to headaches. He had had several severe falls, the first six years ago; he was insensible after the last for an hour, not after the previous ones. His father had hæmoptysis, and died four years ago, much emaciated; a sister had no hæmoptysis, but was affected like the father. The patient had had hæmoptysis himself. He was not anæmic. His aspect was distressed. Pulse 80, regular, steady. There was great hyperæsthesia of the surface; a cold hand applied made him start. The apex-beat of the heart was in the fifth left intercostal space, within or at the vertical nipple-line. The area of cardiac dulness was not increased. No *bruits* were heard with the heart's sounds; they were very weak at the midsternum, more distinct at the apex. The rhythm was quite regular. The first sound was of good length at the apex. There was murmur at the xiphoid cartilage. The jugulars were not full. The upper ribs moved considerably, and the whole chest was drawn upwards in in-

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spiration; the lower ribs expanded very little; the abdomen scarcely moved at all. There was good percussion all over the front of the chest. Air entered freely in both lungs in front during deep inspiration. The breath-sounds were rather harsh. Resonance was fairly good throughout the back, and air was heard entering the lungs fairly well. He complained of shortness of breath, of inability to lie down, and of being put out of breath by the least exertion. He had not had an hour's sleep at night for two months; he dozed a little towards morning. He complained very much of aching and shooting pain in the left side, which, as well as the dyspnœa, prevented his sleeping. There was no cough or expectoration, nor any swelling of the legs. He had no appetite, and was thirsty. He was ordered to have simple diet, beef-tea and milk; and to take twenty grains of saccharated carbonate of iron three times a day, and to have ten grains of chloral hydrate at bedtime, to be repeated if necessary. On the 15th, he had slept from 12 to 2 in the night, and again this morning. He was almost free from pain in the left side when visited, but had it badly a short time since. He had much headache and vertigo. He passed urine with difficulty and pain; he said that he had not passed any till to-day since the 12th. The urine was full-coloured, pretty clear, of specific gravity 1.030, not albuminous. Pulse 64; temperature 100°.—January 16th. He slept five hours last night, and felt better. The left side was tender when I percussed over it. There was no movement over the abdomen; the upper ribs played too much. The chloral was repeated, and he was ordered to have the following draught three time a day. ℞. Ammoniæ carbon. gr. iv; ferri ammonio-citratis gr. viij; tincturæ nucis vomicæ ♏x; tincturæ calumbæ ♏x; aquæ ℥j.—January 17th. He had slept very well last night. Tongue clean. He had no pain in the side now at all. Temperature 98.6°.—Jan. 18th. The bowels had been freely opened; much fecal matter being brought away, with much relief. He had a good night without chloral, and felt better than he had done for two or three years.—January 20th. He slept well, and felt much better. The abdomen at the upper part fell in ten divisions of Dr. Sibson's stethometer in deep inspiration.—January 24th. The breathing now was quite normal. The abdomen while he was recumbent rose fully in inspiration, and fell in expiration; this was the case with the upper part, which a few days before fell in during inspiration. The upper ribs moved a little—not more than normal.—February 6th. He had been an out-patient ten or twelve days, and was going on very well. Pulse steady and good, 80. The upper ribs in the recumbent posture moved slightly; the lower more; the abdomen still more. A trace taken January 17th was tolerably normal. The rise was low, and rather sloped; the apex bluntish; the descent long and gradual, with one well marked notch, and several minute ones.

*Remarks.*—The symptoms in this case were by no means plain to read—at any rate, the first. Subsequently, and chiefly by observation of the effects of remedies, they became more intelligible; and, on retrospect, the pathological story comes out sufficiently clear. The phenomena observed were, of a positive kind, dyspnœa, orthopnœa, incapacity for exertion, insomnia, left-side pain, altered respiratory movements, paresis of the diaphragm; of a negative kind, healthy state of the lungs, heart, and kidneys, and of the vascular system generally. The family history pointed to the probable existence of the tuberculous diathesis in our patient, and his personnel suggested the possibility of traumatic lesion of his brain or cord.

The chief symptom, around which several of the others grouped themselves, was the singular paresis of the diaphragm; and to this, therefore, our attention was specially directed. As a male, he ought to have used his diaphragm very much in breathing; and therefore the inaction of this great muscle was even more significant than it would have been in a female. Such inaction has been observed in empyema and in peritonitis, in advanced cases of progressive muscular atrophy, in sufferers from plumbic toxæmia, and in the hysterical (so called). It has not

been observed, but might be presumed, to exist in cases of fatty degeneration of the diaphragm. A little reflection will enable us, looking back, to exclude all these conditions as being in any way concerned in our patient's trouble. There was no sign of pleurisy, of peritonitis, of lead-poisoning, or of muscular atrophy; while the result excludes, I suppose, the possibility of fatty degeneration. Nevertheless, I must say I had some suspicions for a while that this morbid change might lie at the root of the matter; and these were not entirely dissipated until the efficacy of the remedies was clearly pronounced. Mr. Callender (*Lancet*, 1867, Jan. 12) has recorded six cases of fatty degeneration of the diaphragm, but they were all complicated with a similar state of the heart; and it does not appear that the state of the diaphragm had attracted attention during life, so that we cannot affirm whether it was paralyzed or not.

It remains, therefore, to be considered, whether the symptom in question was a nervous phenomenon—was, in fact, a paralysis of the phrenic nerves. Two possibilities present themselves here—one, that there was actual lesion of the nerve-centres; the other, that the disorder was a paralytic neurosis. The falls which he had undergone—one of them from a great height—might well have injured his cord; but the absence of any paralysis of the limbs or sphincters was an insuperable argument against this view. Had his cord been contused by a fall, the injury could not possibly have been confined to the nerve-cells connected with the phrenic nerve. The second view, therefore, seems the only one admissible. It was corroborated to some extent by the existence of left-side pain, which is extremely common in neurolytic conditions both in males and females, and by the presence also of general hyperæsthesia, and, as it would seem, of spasmodic stricture. The result of treatment was very positive, and leaves no doubt in my mind that no organic lesion existed, and that we had only to deal with a rare variety of neurotic disorder. As I mentioned before that palsy of the diaphragm was met with amongst the hysterical, you will perhaps expect that I should so designate the neurotic paralysis in our case; but I decline to do so, because the patient presented none of the recognized features of hysteria. He had had, so far as we know, no globus, or fits, or aphonia, or dysphagia, or paraplegia. There was no varying or shifting of his troubles from one part to another; no tendency to exaggeration or deception—nothing, in fact, to distinguish him from any *bonâ fide* sufferer. His aspect was distressed, and quite unlike that of some invalids, who assure you with calm countenance that they are suffering "agonies of pain." I pass by the slight difficulty that our patient did not possess a uterus, and so could not legitimately be reckoned an ὑστερικος. Let me strongly advise you to reserve a place in your minds for the idea of functional paralysis, either depending on remote irritation, or on toxæmia, or simple exhaustion; and to abstain from applying loosely the term "hysterical." It were better, I think, laid aside altogether, as it will, I suspect, always carry with it a savour of more or less suspicion that the disorder is not genuine, not physical, but more or less consciously simulated. In very many instances this suspicion is unjust, in others it is well founded.

I regard, then, our patient as having suffered from some cause which does not appear a functional paralysis of the centres belonging to his phrenic nerves. Possibly he has an infirm constitution of his nervous system. The hereditary tendency to tuberculosis which he evidently had may have become converted into this other deterioration. It does not seem very clear why aphonia should be reckoned a necessary symptom of palsy of the diaphragm, as has been somewhat too broadly stated. The diaphragm is not an expiratory muscle; and, if a tolerable amount of air be inspired by the other muscles, sufficient to aërate the blood, it seems probable that quite a sufficient current would traverse the glottis during expiration to produce sounds. In fact, it does not appear that the aphonia is at all complete: the patients can speak, but are sooner or later obliged to desist for

lack of breath. Eulenburg says the voice becomes weak, but phonation itself does not suffer. This was the case in our patient, and seems to have been so in the case which Eulenburg relates. In Bazire's case (*vide British Medical Journal*, 1867, vol. i. p. 597), laryngoscopic examination detected nothing abnormal about the glottis. The vocal cords approximated normally when she uttered a sound. This, however, is scarcely sufficient to prove that the same effort could be maintained for any continuance. It seems rather surprising that disorders of the diaphragm are not more frequent, considering the long course of the phrenic nerves, and their great liability to be pressed on by enlarged glands or indurated exudation-masses in some part of their course. Dr. Bazire well observes that the results obtained by galvanizing (faradizing) the phrenic nerves will at once indicate whether the palsy is due to a structural alteration, or is merely functional. In the latter case, the muscle will contract powerfully when its nerves are stimulated; in the former, it will respond feebly or not at all. Duchenne was the first to show that paralysis of the diaphragm is not of itself fatal, as had previously been thought; but he observes that, though the patient may survive long, his condition is perilous, inasmuch as a slight bronchitis may induce fatal asphyxia.

A remarkable symptom in Duchenne's patient was, that forced inspiratory efforts, instead of satisfying the want of air which she felt, greatly increased her distress. She expressed very well what she felt at such time by saying that her bowels suffocated her by rising up into her chest. In Bazire's case, however, no such sensation was ever felt; nor was it complained of by E. H., nor is it noticed by Eulenburg in the case he relates. In all these patients, the causation was obscure. The last had certainly been chilled, and got a stiff neck nine days before the paralysis came on; but it seems very doubtful whether this had any thing to do with the latter.

In the way of treatment, localized faradization of the phrenic nerves is advised by Duchenne de Boulogne, and proved strikingly effectual in Eulenburg's case; in Bazire's, it failed; in my own, it was not employed, as the tonics and sedative were so speedily successful. Whatever be the cause of the paralysis, faradic stimulation of the muscle and its nerves seems desirable, although other treatment may be varied according to the special features of the case. Even in the advanced stage of progressive muscular atrophy, faradization has proved successful in saving the diaphragm.—*Brit. Med. Journ.*, May 31, 1873.

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*Clinical Lecture on Dysidrosis (an undescribed eruption)*. Delivered at University College Hospital, London. By TILBURY FOX, M.D. Lond., F.R.C.P., Physician to the Department of Skin-Diseases.

GENTLEMEN: I am desirous to-day of directing your attention to a disordered condition of the sweat-follicles and the sweat-function which you will not find described in books. In fact, I shall depict to you for the first time a disease of the skin which is, as a rule, diagnosed as eczema, but is a separate and distinct affair. I will, in the first place, read to you the notes of a case which has recently been under our notice amongst the out-patients.

Mrs. E., aged 36, came to the hospital on May 27th with her child, who had ringworm; and she showed on the back of the left hand a patch which had all the appearance of being ringworm. She was ordered some mercurial preparation, and returned on the 30th with the hand in an inflamed state, but the ringworm was well. She then made a remark about herself which led to a closer examination of her case. It appeared that about Christmas she noticed a little itchy pimple at the back of the ring-finger of the left hand, and presently a circle of little bladders developed round about this pimple. The disease was very irritable, and had never really gone away since Christmas. It never increased much until a fortnight ago. The mercurial application seemed to cause its spread. She always noticed a tendency in the eruption to spread, and the hand felt hot and irritable after washing.

The general health is good; but the

woman feels "so very weak that, if she goes to scrub or sweep a floor, she trembles very much, and is obliged to sit down and eat a crust and drink some porter; and then she can get on." If she is much upon her legs, she soon tires, and the legs ache. She often has sick-headache. In the recent cold weather, if she began to work, she "used to get into a great heat, as on a summer's day." After eating, she flushes, and generally feels sick. She is almost always perspiring, and especially of late. Whenever she changes her clothes, even in the coldest weather, she is always very damp. Her feet are always cold. She is suffering from menorrhagia. For the last two years, she has been generally unwell every fortnight, "and very much so for two or three days." She never gets a good night's rest; is "always working, or travelling, or sending up a large dinner, or something of the kind, in her sleep." She often wakes up suddenly in the night, startled, fancying she is jumping or flying, or leaping off heights, etc. She is not hysterical, but is very "nervous." She suffers also from a tight pain round the waist at night; but this appears to be due to flatulence. The bowels are very obstinate indeed.

*Present Condition.*—Both hands and arms and upper arms are affected—the hand and arm to which no mercurial ointment has been applied, on the left side, equally with those of the other side. There are scattered papules, which, on close examination, are seen to be in reality vesicles; and also very distinct vesicles, of the size of millet-seeds—some of them having a red base, and in some cases being crowded together in little groups, more or less scattered all over the backs and sides of the fingers, and the back and front of the hand, and the whole forearm (back and front), and the arm up to the shoulder, especially its inner aspect. In some cases, the vesicles have run together, so as to form minute bullæ; on pricking these bullæ, a drop of very clear fluid exudes, and it is alkaline. Between the fingers, the cuticle is in some cases raised slightly by a layer of fluid beneath. It is white and macerated, especially at the web of the fingers; and the fluid is faintly acid; it is also offensive. There are no crusts anywhere. On the palmar aspect, there are scattered isolated vesicles about the fingers; and towards their tips a number of minute transparent points, resembling sago-grains, are visible under the skin—some thirty or more. These points are not raised, but are seen through the cuticle, and are clearly sweat-follicles distended by sweat. The front of the forearm appears as if it were the seat of diffused eczema. Over the palm of the hand itself, there are transitional stages between the solitary vesicle and the macerated patch. For example, about the root of the fingers, and extending across the whole palm, is a band, an inch wide, of macerated cuticle, upraised by clear fluid beneath, and looking like a piece of very thin moistened chamois leather of light colour, or wet parchment; and this runs up a certain way along the outer boundary of the hand. Next comes a line of cuticle upraised by clear fluid, and situated nearer the centre of the palm. It is half an inch wide, of transparent aspect, and fluid can be let out from beneath. Next come groups of vesicles; and, lastly, isolated vesicles; and those along the inner side of the little finger are like tapioca-grains. On the right side, at the ends of two of the fingers on their palmar surface, there is an appearance as if there were boiled sago-grains beneath the skin; and this is found to be due to distended sweat-follicles filled with sweat, and seen through the cuticle. If one of these transparent places be pricked, clear fluid oozes away from it. Towards the base of the fingers there are groups of distinct vesicles, themselves separate the one from the other. At the junction of the fingers with the palm of the hand, there are white patches of the size of sixpences on two fingers, formed of uplifted and macerated cuticle. On the forearm, over its front, are scattered vesicles on a red base; and here and there little red points, that look like red papulæ; but these are vesicles whose contents have dried up without rupture of the cell-wall, or abortive vesicles.

Now it is to be observed that there are no crusts; and the fluid contained in the vesicles remains perfectly clear until it

dries away or escapes, when the cuticle shrivels and peels off; or until it macerates in certain places the cuticle.

It is not difficult to trace the stages from one place to another. First, the sweat-follicles are distended, *and are not raised;* but are seen through the cuticle. Then, as the collection of sweat increases, there are distinct vesicles with very transparent contents; these vesicles may run together if the outpouring of sweat continue; and, in cases where the secretion is excessive, very large bullæ indeed may form. Presently the cuticle becomes macerated in some places; and white patches, formed of uplifted cuticle, are produced. In this case, there was a very offensive and sour odour perceptible about the hand or arm.

The patient complained greatly of burning pain about the seat of eruption. She states that she once had the shingles severely and painfully, and that the smarting and burning she feels with the present disease are of the same kind. The eruption has shown a tendency to appear about the face and legs.

*Remarks.*—If you have followed my description of the case, you will have no difficulty in appreciating the nature of this disease. Its anatomical seat, as seen in the earliest stages of the disease, is clearly the sweat-follicles. The vesicles result from distension of these follicles by sweat, which, on examination, is not found to bear any resemblance to the fluid exuded in inflammation; nor does it contain pus, or give place to crusts. The bullæ are formed by the coalescence of vesicles; the papulæ, by the abortion of vesicles; the white patches of uplifted cuticle, by the maceration of the latter by sweat, which becomes, from the access of air, acrid and sour.

Now, at first sight, this disease looks like an acute eczema; but it is not so, though the acrid sweat may so far irritate as to excite an eczema. Do not forget this. You will have observed that this disease does not begin as a serous catarrh of the papillary layer, as does eczema, but by distension of the sweat-follicles. When there is no sero-purulent discharge about it, the fluid in the vesicles remains quite clear so long as it is confined; and during the whole course of the disease there is no crusting. It is altogether unlike eczema with its sero-purulent discharge, stiffening linen, and drying into thin yellow crusts.

The disease may look like erythema papulatum, but only in so far as there are abortive vesicles present; and these clearly do not constitute the chief feature.

The disease varies greatly in extent and duration; it may happen that one or several successive outbursts of the eruption occur, and the disease may last a week or ten days, or several weeks if there are successive outbursts. The case which I have described is a very marked one. In some cases we have a few little flattened itchy vesicles, about the sides of the fingers, succeeded by a drying up of their contents, and a mere peeling off of the cuticle. In some cases the feet are affected, and then we have between the toes, especially at the junction of the toes with the foot, small white patches, produced by uplifting and maceration of the cuticle by acrid sweat. These cases are confounded with, and always called, eczema. There is oftentimes a great deal of very troublesme itching, especially at night, and patients complain of it bitterly, as it is excessively annoying, and disturbs them from getting a fair night's rest. In other cases we have the whole foot affected, in others coincidently the hands and feet, or the face and arms. I have noticed in gouty subjects, that the disease is intensified in severity, I suppose on account of the irritable character of the blood.

The disease, gentlemen, is not described in books, since it is always regarded as eczema, but I have explained to you that it is wholly unlike eczema. The resemblance is accounted for by the fact, that in both diseases there are vesicles which are crowded together, but the character of the fluid uplifting the cuticle, and its subsequent behaviour, the source of this fluid, the anatomical seat of the disease, are wholly and entirely different. The disease is not the hydroa of Bazin, under which term a host of different things have been classed—urticaria bullosa, erythema papulatum, miliaria, and the like.

Of course, in many diseases, excessive

sweating occurs, as in the case of idrosis, miliaria, and sudamina; but then the sweating is only an accidental feature, and accounted for by the general disturbance; but in this disease, the sweat-disorder is the main and sole disease present. But I have noticed that it always occurs in those who too freely perspire, in those who are depressed, weak, and get quickly exhausted, and in connection with, oftentimes, anomalous nerve-symptoms. The cause of the sudden outpouring of sweat is doubtful. It is, probably, some disturbance of the nerve-influence.

Now as to treatment. It is of no use trying to cure the disease by local measures, though you can moderate the irritation, and inflammation, and prevent the sweat from becoming sour and irritating. The internal remedies are diuretics, with a view to relieve the skin, with large doses of quinia and nux vomica. Locally, I cover up the parts in the acute and early stage, with some simple cerate, with liquor plumbi, rubbed into it, and perhaps carbolic acid, in small quantity. Then, later on, I coat the parts with starch, and calamine powder, and later on prescribe the balsam of Peru, twenty grains to an ounce of lard, with a little white precipitate. Most cases do well. In the simple instance of the disease you give the quinia internally, with arsenic if you like, and diuretics if need be, and locally protect the parts with calamine lotion.

I have termed the disease dysidrosis, because nature seems to have a difficulty in getting rid of the secreted sweat, which remains to distend the follicles, and to macerate the tissues. The disease is nothing more than retention of sweat and its results. Dysidrosis bears the same relation to the sweat-glands that acne does to the sebaceous glands. — *Brit. Med. Journ.*, Sept. 27, 1873.

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### HOSPITAL NOTES AND GLEANINGS.

*Remarks on Cases of Vertigo, Reeling, and Vomiting, from Ear Disease.* Under the care of Dr. HUGHLINGS JACKSON, at the London Hospital.

A man, thirty-one years of age, came to the out-patient room on August 1st, 1872, for attacks of auditory vertigo. The following account of his first attack may serve as a specimen. One day, about three months before his admission, he was, when walking home from work, attacked very suddenly by *swimming in the head;* he would have fallen, had he not sat down; he felt sick, and also very warm. A friend helped him, or he could not have walked home; when he looked at the ground it seemed to be going round. When home he took some carbonate of soda, and after this he *vomited.* He slept well that night, and next morning felt well, except for a nasty taste in his mouth. He had several attacks of essentially the same kind afterwards. Such a set of symptoms coming on paroxysmally suggested disease of the ear. It is worth while mentioning that the patient said there was nothing the matter with his hearing; but, oddly enough, it was found that he could not hear at all on the right side; and, before the examination of it, it was plain that the right ear was very defective, as was shown by his promptly turning his head to place his left ear towards those who spoke to him. Twelve months before he had put a piece of tobacco soaked in rum into the right ear, for the relief of toothache. The syringe brought away a large plug of wax, with bits of tobacco. After this he heard very much better, but there was still some deafness. A plug of wax in the external meatus would be a sufficient cause for the attacks the patient had; but he had another attack, although a slight one, after the meatus had been thoroughly cleared out.

Such cases have long been described; they have been described very recently and most ably by Knapp (*Archives of Ophthalmology and Otology*, vol. ii. No. 1). But it is not widely known that ear disease gives a sufficient explanation of the group of grave nervous symptoms mentioned. The tendency is to put down the giddiness, reeling, and vomiting, to disorder of the digestive organs, and especially to some affection of the liver. But in the above reported case and in many others, there is no dyspepsia, and no evidence at all of liver affection. It is not

denied that there is *a vertigo a stomacho læso;* but it is asserted that, of the numerous causes of vertigo, aural disease is a very important one. The "bilious vomiting" is what misleads so very often in diagnosis. Bilious vomiting is, however, of no particular value as evidence of disease of the liver. Bile will always be found in the ejecta after long-continued and urgent vomiting, however caused. And as to vomiting itself, it is a symptom which is found under the most different circumstances; it is found with cerebral tumour, renal calculus, Bright's disease, and, as we see, with aural disease. Those who would not accept the explanation of the dependence of vomiting, reeling, and vertigo on ear disease, are at any rate bound to examine the ears of the patients who suffer those symptoms; if they do, they will be struck by the frequent coincidence of noises in the ear, deafness, etc., with the paroxysmal occurrence of the symptoms mentioned.

The affection of the ear varies in its nature. Meniere, who first described this group of symptoms, supposed the semicircular canals to be in fault. It is well known that the auditory nerve supplies two parts, the cochlea and the semicircular canals. The cochlea is for hearing, the canals (according to Goltz) for regulating movements of the head and trunk. It is certainly a fact that injury of these canals in lower animals produces disorderly movements, and, as stated, Meniere believed that injury of them by disease in man produces the disorderly movement of reeling (vertigo is rudimentary or incipient disorder of movement). But it is enough if the contents of the semicircular canals be interfered with indirectly; for example, if they be subjected to increased pressure from disease in the tympanic cavity. But, as Knapp says, the deafness shows that the cochlea must be affected as well; at any rate, the accepted theory is that the cochlea only is for hearing (Helmholtz supposes the cochlea to be the part for musical sounds, the semicircular canals for noises). Knapp has observed in some cases of Meniere's disease what he calls a contraction of the field of audition (analogous to contraction of the field of vision); there is, in other words, deafness for certain groups of musical sounds, and this, Knapp considers, is positive proof that the cochlea is implicated in addition to the semicircular canals.

Dr. Hughlings Jackson thinks that the function of the "canal" division of the auditory nerve is for the regulation of intervals of movements (for more automatic movements occurring in the intervals of a succession of voluntary movements). Hence the association with the other division for musical sounds; both divisions are in action in dancing to music. He believes that the symptoms of sea-sickness may be explained on the supposition that the contents of the semicircular canals are rudely dealt with in the unaccustomed movements of sailing on a rough sea.—*Lancet*, Sept. 6, 1873.

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*Treatment of Thoracic Aneurism by Electro-puncture.*—The patient with thoracic aneurism, whom Mr. Beck has been treating by means of electro-puncture, died on the night of the 23d of September. He was suffering from a large and rapidly gowing aneurism of the descending aorta, which not only caused bulging of the lower ribs on the left side, but had eroded several of them, and gave rise to a pulsating tumour just below the angle of the scapula. Mr. Beck first operated on the 2d instant; he inserted the wires into the most prominent part of the tumour, and passed the current between them for about an hour and a quarter. The effect, as we stated in the *Medical News* for October, was very encouraging; the tumour became decidedly firmer, the impulse less heaving, and the pain was greatly diminished; there was no irritation about the seat of puncture. This improvement lasted five or six days, when the impulse became stronger, and the tumour began again to enlarge. On the 10th, Mr. Beck repeated the operation; but this time the improvement was but slight, and of a still more fugitive character. A few days afterwards, it was found that some inflammation had been set up round one of the punctures; and, on pressure, a small quantity of pus escaped. The aneurism, though it never became absolutely diffused, now spread

rapidly under the skin of the back, and it was found that the dulness was extending upwards over the left side of the chest; that the heart was being pushed more and more to the right, and the lung becoming compressed. The aneurism, as the necropsy showed, had burst into the left pleura. The patient gradually sank, and died of exhaustion. Before death, the skin round the inflamed puncture had become quite dark and gangrenous. The lesson from this case is, that treatment by electricity must be commenced at an early period of the disease, in order to give any prospect of success. That it does induce extensive coagulation in the sac, seems evident; and it is very desirable that any method which gives reasonable hopes of curing what has hitherto been a necessarily fatal disease, should be thoroughly tried before being condemned.—*Brit. Med. Journ.*, Sept. 27, 1873.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Needle Swallowed by a Child—Removed Six Months Afterwards from the Thigh.* By B. Schermerhorn, M.D., of Buskirk's Bridge, N. Y.—Emma S., a child of fourteen months, was brought to me June 18, 1873, by its parents, who gave the following history. About six months ago the child swallowed an ordinary sewing needle which lodged in the throat, and was pushed downward with a swab in the hands of its grandmother. From that time until about a month since it gave the child no trouble; since then it has been more or less worrisome and fretful, and during the last night before being brought to me it cried the whole time. Upon dressing the little one in the morning the mother's attention was drawn to a little elevation of the skin, like a pimple, upon the outer aspect of the left thigh, midway between the knee and hip-joint. Thinking of the needle they came with the child to my office, and after laying open the cuticle I removed a needle an inch and a quarter in length, which lay with its eye to the surface.

*Treatment of Sore Nipples.*—Dr. Fordyce Barker, in a recent clinical lecture on this subject (*Medical Record*, Sept. 15, 1873), advises that the woman be allowed to completely recover from the fatigue of confinement before applying the child to the nipple.

The first stage of parturition is that of exhaustion. The whole effort of the system has been used to accomplish this result, and so complete is the exhaustion, that it is very commonly manifested by nervous chills. If the woman is permitted to get a few hours of sleep, her exhausted nerve-power will be restored, and *then* is the time to direct that the child should be placed to the breast.

The main reason for this is, the breast is not now distended, and the nipple is easier drawn out. The traction excites the more rapid secretion from the breast, and the first secretions from the breast are of great benefit to the child as a laxative, being its first proper food. It is then that the nipple can be more readily grasped by the child, and properly formed. If, however, you wait until the secretion of milk has taken place, and the breast has become distended, before applying the child, the distension itself causes obstruction to a free flow through the ducts, and the nipple and breast may become a very great source of irritation.

There are some cases in which the nipple congenitally is so short that the child cannot get hold, and it must be drawn out by some mechanical appliance. The most common method resorted to for accomplishing this is the old-fashioned application of a bottle, which has been filled with hot water and emptied, and the use of the breast-pump.

A few words with regard to breast-pumps. Most of them are constructed upon principles utterly devoid of common sense. Most of them have so small an opening in the part applied to the breast that the nipple is constricted, and the milk cannot flow at all after the first two or three exhaustions of the instrument.

The essential requisite for an efficient breast-pump is a large bell-shaped extremity, so that the nipple is not at all constricted by the narrow diameter which is applied over it.

The pump which meets the indications

most satisfactorily, and which has come to my notice, is what is called Mattson's breast-pump, and it is a most excellent instrument.

With regard to treatment of the sore nipples, the following are the rules which chiefly govern me in the management of these cases: If the nipple is inflamed, apply a poultice until the inflammation is subdued, and then apply a solution of nitrate of lead in glycerine, ten grains to the ounce. This is also the most complete and perfect prophylactic against the occurrence of sore nipple that I know of. This solution should be applied immediately after nursing, having first washed the nipple perfectly clean.

The application must also be washed off every time before the child nurses. It is almost a specific, when properly used, against excoriations and ulcerations. If the tendency is quite strong to sore nipples, the solution may be used of the strength of 15 grs. to the ounce, or even ℈j; but as a rule the 10 gr. solution is sufficient. Next, where the cuticle is demanded, and we have a raw surface, or it becomes so irritated that there is a tendency to an abrasion, the indication is to form an artificial cuticle, which will entirely protect the parts, and yet permit the milk to pass through it.

For this purpose collodion has been extensively used. The objection to the collodion is this, that it contracts as it dries, and thus itself becomes a source of superficial irritation and discomfort, and does not readily permit the flow of the milk. I have used for this purpose, and with the most satisfactory results, the compound tincture of benzoin. Wipe the nipple dry after the child has nursed, and with a camel's-hair brush apply four or five coats of this tincture.

The first application may produce some burning, but when once applied this will be entirely overlooked, and the woman will desire its reapplication. This forms a most excellent artificial cuticle, and at the same time permits the flow of milk without obstruction. Cicatrization will take place under this coating, and the patient will thank you for the benefit received. When the fissure is at the base of the nipple, very small it may be, but accompanied by the most severe and agonizing pain, the most satisfactory method of management is to touch the fissure with a fine point of nitrate of silver, and apply over this the comp. tincture of benzoin as before.

When the inflammation and ulceration have gone on to such an extent as to destroy the surface of the nipple, and there is danger of the inflammation extending back to the mammary gland, do not allow your patient to torture herself by allowing the child to nurse. Remove the child entirely, and empty the breasts by the breast-pump or by rubbing.

I then use as an application in these cases the following:—

℞. Rose ointment..... ℥j.
Carb. magnesia..... ℈j.
Calomel..... gr. xxx.
M.

These ingredients should be rubbed together very carefully, and it should be freshly prepared, perhaps every twenty-four or thirty-six hours. If the child is permitted to nurse at all, it should be done entirely through an artificial shield, and the best shield is one made of the cow's teat. The objection to the India-rubber shields is, that there is an offensive odor emitted from them, and they are very apt to make the child's mouth sore.

If, however, it becomes necessary to use the shields which are in the market, in selecting them get a broad base, what is called the L-shaped glass, in the same manner as in the selection of the breast-pump. The ordinary nipple-shields seen in the stores are simply abominable.

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*Resection at Hip-joint; Fracture of Femur.*—Dr. F. H. Hamilton, at a recent meeting of the New York Pathological Society (*Med. Record*, Aug. 1, 1873), presented the head, neck, and trochanter major of a femur resected at Bellevue Hospital before the class, April 12, 1873. The patient was a boy, æt. seven, who had morbus coxæ in its third stage. He was now progressing favourably toward recovery. The only point of special interest in the case was the fact that, while employing a slight amount of leverage to disarticulate the

bone, the femur broke near its middle. He was surprised how little force was requisite to break the femur under these circumstances; and as he had not seen any allusion to this danger in the surgical treatises, he thought it important that he should call the attention of surgeons to the matter. The fracture was transverse, and under the support of pasteboard splints it united speedily without deformity.

Dr. Sayre said this accident had happened in two cases while he was operating.

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*The Physician's Visiting List.*—Messrs. Lindsay & Blakiston, of Philadelphia, have just issued their *Physician's Visiting List* for 1874. The fact that this little work has reached the twenty-third year of its publication is convincing proof of its value to the profession.

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Obituary Record. — Died, at West Chester, Pa., September 11, in the 70th year of his age, Wilmer Worthington, M.D., an eminent practitioner and an excellent, amiable, and high-minded gentleman. Dr. W. enjoyed the confidence of his numerous patients and the esteem and respect of all who knew him. He was successively President of the Pennsylvania State Medical Society, a member of the Pennsylvania Assembly, the Speaker of the Senate, Surveyor of the Port of Philadelphia, and Secretary of the Board of State Charities, which last position he held at the time of his death.

——, September 9th, of apoplexy, Geo. W. Bayless, M.D., Prof. of the Principles and Practice of Surgery in the Medical Department of the University of Louisville.

——, suddenly, in Washington, D. C., Sept. 20th, aged 67, Dr. Thomas Miller, Emeritus Professor of Anatomy and Physiology in the Columbia College, and a prominent practitioner of the District of Columbia.

## FOREIGN INTELLIGENCE.

*Deaths from Chloroform.*—A case of this has recently occurred at Guy's Hospital. The patient was a male aged 37, admitted under the care of Dr. Fagge, with an enlargement of the liver, the nature of which was not clear. Mr. Turner administered chloroform by Dr. Fagge's desire, with a view to the exploration of the tumour by puncture. The patient went on well until the conclusion of the convulsive stage, the pulse being fair and the respiration good. At this point the pulse suddenly failed, the patient turned blue, and gasped. Restorative measures were immediately employed, but without success, though artificial respiration and galvanism were continued for nearly an hour. By *post-mortem* examination, the liver was found greatly enlarged, lardaceous, and containing numerous gummatous masses, and closely adherent to the diaphragm. The heart was apparently healthy. — *Brit. Med. Journ.*, Sept. 13, 1873.

Another case is recorded in the *Medical Times and Gazette* (July 12, 1873). On June 28, Ann T., aged 45, consulted Δ (who reports the case), concerning a fracture of her right arm received twenty-five days before. It was intended to place the joint on a bent splint, and as any movement of the joint caused great pain, one drachm of chloroform was given. In about two minutes, the woman not being in the slightest degree insensible, a second portion, about one drachm, was poured on the handkerchief. In about two minutes her struggles ceased, the pulse remaining good. The handkerchief was removed from the face and two pulls were given to reduce the dislocation of the radius, when it was noticed that the woman's face was livid, her pupils dilated. No pulse could be felt at the wrist, and her breathing had ceased. Artificial respiration was fruitless.

The *British Medical Journal* for Sept. 27, 1873, records the death on the 9th of September, from the inhalation of chloroform, of Mr. James Cruickshanks, a practitioner of medicine of Ayton, Berwickshire. Unfortunately he had for several years habituated himself to the occasional use of chloroform for the relief of fatigue or other uneasiness, although seriously warned of the danger of the practice by a medical friend. On the morning of the 10th instant, he was found in his ordinary dress,

lying on his face across his bed, cold and stiff, death having evidently taken place at least twelve hours previously. A two-ounce bottle, still containing about two drachms of chloroform, was beside him. It appears that he had retired to this room shortly after dinner on the 9th; and the contents of the stomach having been vomited, his face lay in a mass of undigested food, which, in his state of insensibility, produced suffocation. He was about 45 years of age.

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*On a Case of Syncope following the Inhalation of Chloroform.*—Mr. Henry Smith, Surgeon to King's College Hospital, London, reports (*Lancet*, July 26, 1873) the following interesting case, which is another illustration of the grave responsibility the surgeon assumes in administering *chloroform* by inhalation.

A gentleman, aged thirty-five, who had resided in India for some time, and who had become quite blanched through bleeding from the rectum, consulted Mr. Smith, who gives the following report of the case:—

I found that this loss of blood resulted from two internal hæmorrhoidal tumours, which I resolved to remove. The patient was in a very weak state; but it was not considered desirable that he should submit to any further loss of blood, and a few days after I proceeded to operate with the clamp and cautery. A most careful and experienced chloroformist administered the agent by means of lint—in my private practice I will not permit the employment of any other method if I can help it—he, at my special request, being doubly careful in watching the chloroform, as the patient was so feeble. The operation was proceeded with and completed in a few minutes without any loss of blood; and the patient so far recovered from unconsciousness as to commence talking and laughing somewhat loudly, but I did not notice if he raised his head from the pillow. The talking ceased, and suddenly we found the man apparently dead, without pulse or breathing. We rapidly set to work to restore animation by the usual methods—violently slapping the chest and face, and for a moment it appeared with success, a slight movement of the chest following; but vigorously as we pursued these methods, the deathly pallor increased if possible, and we all felt convinced the man was dead. We then practised Silvester's method, but without avail until the finger was thrust down the throat on to the top of the glottis. This excited a slight quiver. Our energies were redoubled, and slowly we had the inexpressible pleasure of seeing our patient emerge from the most dangerous position I have ever seen a human being get out of.

I think it right to note this case, of which I have never seen the like before. I have had in my own practice four cases where the most imminent danger arose from the exhibition of chloroform, and I have seen three or four others where the recovery was marvellous; but this was the first case I have ever seen where the effects of chloroform had gone off, the patient had become sensible, and then sudden and most dangerous syncope had occurred.

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*Treatment of Diphtheria.*—Dr. Lolli, of Trieste (*Wiener Med. Zeit.*, July 8) states that while diphtheritis is very fatal in that city, he has lost less than two per cent of his cases in consequence of the efficacy of the treatment he employs. He does not resort to cauterization, bleeding, purgatives, or emetics, save in very exceptional cases. He maintains the skin in a state of great activity from the very first, by keeping the patient in bed, and, if necessary, applying warm applications or mustard. These measures are continued until all local and general symptoms have disappeared. As the sole medicinal agent, he employs the following mixture in different concentration: Liq. calcis ℥iv ad lb. j, liq ferri sesquichl. ℈j ad ℥ij, phenic acid gr. j ad ℈j, mel. rosæ ℥j. With this he paints the fauces every two hours, and gives two spoonfuls of the same in water every two hours.—*Med. Times and Gaz.*, Aug. 16, 1873.

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*Distilled Cherry-laurel Water as a Vehicle for Narcotic Injections.*—M. Luton states that distilled cherry-laurel is the best vehicle for narcotic hypodermic injections

as morphia and atropia. It prevents mouldiness of the solution better than any other distilled water, and it does not irritate the tissues any more than common distilled water.—*La Tribune Médicale*, 14 Sept. 1873, from *Rep. de Pharm.*

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*Liebig's Extract.*—In a letter to Joseph Bennert, Dr. PETTENKOFER enters into an elaborate exposition, or rather vindication, of Liebig's extract. Like all alimentary novelties, that renowned preparation has had to fight its way into popular acceptance through at least two initial prejudices: first, a suspicion as to its wholesomeness, to use no stronger phrase; next, a scepticism as to its possessing any specific virtue whatever. Both these barriers the extractum carnis has at length surmounted, though three-and-twenty years have elapsed since its discoverer first produced it in the Royal Laboratory at Munich. How little its assailants understood the object of their attack may be inferred from the charges they brought against it. "The extract," said they, "containing as it does neither albuminoids, nor fat, nor hydrates of carbon, is not an alimentary substance." Of course it is not. It was precisely on the principle of eliminating from the extract every particle of albumen, of fat, even of gelatine, that Liebig proceeded. And with what result? To produce, not an alimentary substance strictly so called, but a condiment which has a distinct and unique place in dietetics. The *rôle* of condiments in the complex action of nutrition is but partially appreciated, and the most natural condiments are usually neglected for others much coarser, more stimulating, but really less efficacious. Voit, the most recent experimenter in dietetics, confirmed the popular impression that the flow of gastric juice to the walls of the stomach may be accelerated even by the sight of meat, as when he witnessed in a fasting dog, in which he had established a stomachic fistula, the immediate rise of the juice when he offered, without giving, the animal a bit of meat. Bouillon, he further maintained—warm and well-boiled bouillon—is the simplest and best digestive, and it is from this premise that Pettenkofer vindicates for the extract its paramount claims as a condiment. These it owes to the mixture of salts, different, indeed, but combined in definite proportions, in a ratio which the organism imperatively demands, and the slightest deviation from which would constitute a veritable impurity. No amount of the best meat can take the *rôle* of the extract any more than milk can play the part of cheese or butter. The product of Liebig is neither a nutrient nor an alimentary substance capable of economizing the albumen, the fat, or the carbo-hydrates; it is simply a condiment, but one of such efficacy that Pettenkofer does not hesitate to anticipate for it the chief place among such aids to digestion, not only in the sick-room, but in common everyday life. It has served him as a text for a very instructive essay on nutrition in general, and though much that he says is recapitulation, it is recapitulation of a kind that has a novelty of its own from the clear and discriminating eye he passes along the series of discoveries bearing on the physiology and application of food.—*Lancet*, Sept. 30th, 1873.

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*Treatment and Utilization of Sewage.*—The following are the conclusions of the Committee of the British Association for the Advancement of Science in regard to this most important sanitary subject:—

"I. All conservancy plans, including midden, heap, and cesspool systems, dry ash, and dry earth closets, pail closets, etc., are quite incompetent as solutions of the general question of the removal of the refuse matters of a population; they only deal with a small part of the liquid manure; towns which resort to one of them require to be sewered, and the sewage requires to be purified. The manure produced is in all cases (except in that of simple pails or tubs, where no extraneous materials are added) poor, and will only bear the cost of carriage to a short distance, taking into consideration the cost of collection, that produced by the dry earth system being, even after the earth has been used three times over, merely a good garden mould. Moreover, these plans all violate one of the most important of sanitary laws, which is that all

refuse matters which are liable to become injurious to health should be removed instantly, and then to be dealt with afterwards. With all these plans it is an obvious advantage on the score of economy to keep the refuse about the premises as long as possible, and the use of deodorants of various sorts, or even of disinfectants, proves that this is the case, and that these systems all depend upon a fallacious principle. They should therefore be discouraged as much as possible, and only resorted to as temporary expedients, or with small populations, in very exceptional instances.

"II. The water-carriage system, on the other hand, is based upon a sound principle—that of removing all the refuse matters at once and in the cheapest possible manner by gravitation—and ought to be resorted to in all but the most exceptional cases. The opinion of the committee that all sewers should be made of impervious materials, and that separate drains to dry the subsoil should be constructed where necessary, has already been most emphatically expressed. The freest possible ventilation of sewers, house drains, and soil pipes, in order to prevent accumulations of foul air, is also essential. With regard to the utilization of the sewage, the Committee has come to the conclusion that the precipitation processes that it has examined are all incompetent, and necessarily so, to effect more than a separation of a small part of the valuable ingredients of sewage, and that only a partial purification is effected by them. Some of them may, however, be useful as methods of effecting a more rapid and complete separation of the sewage sludge.

"The upward filtration process only effects a clarification of the sewage, and is therefore no solution of the question.

"By properly conducted sewage irrigation a solution is afforded to the question of sewage utilization. It has already been stated that a precipitation process, or some clarifying process, may be found useful. In all instances it is essential that the land should be well underdrained, and that the sewage should all pass through the soil and not merely over it; otherwise, it has been shown, it will only occasionally be satisfactorily purified. The catch-water, or, as the Committee has termed it, the "supersaturation" principle, is not defensible either on agricultural, chemical, or sanitary principles; an irrigation farm should therefore carry out intermittent downward filtration on a large scale, so that the sewage may be always throughly purified, while, at the same time, the maximum of utilization is obtained.

"It is certain that all kinds of crops may be grown with sewage, so that the farmer can grow such as he can best sell. Nevertheless, the staple crops must be cattle food, with occasional crops of corn; and it is also certain from the analysis of the soil that it has become very much richer, and that the manurial constituents of the sewage accumulate in it. Cattle should be fed on the farm, which leads to a vast increase in the production of meat and milk—the great desiderata of the population producing the sewage. Thus the system of farming must be specialized and capital concentrated, the absence of which conditions has proved a great barrier to the satisfactory practical solution of the sewage question.

"In reference to the influence of sewage farms upon the public health, the following important information is given: The Committee has not been able to trace any ill effects to the health of the persons living around sewage farms, even when badly conducted; nor is there any proof whatever that vegetables grown thereon are in any way inferior to those grown with other manure. On the contrary, there is plenty of evidence that such vegetables are perfectly suited for the food of man and beast, and that the milk given by cows fed on sewaged grass is perfectly wholesome. Thus Mr. Dyke, Medical Officer of Health for Merthyr Tydfil, states that since the abundant supply of milk from the cows fed on irrigated grass the children's mortality has decreased from 48, 50, and 52 per cent. of the total deaths to only 39 per cent., and that so far from diarrhœa having been made more prevalent by the use of sewaged cabbages, 'last year the Registrar-

General called attention to the fact that diarrhœa was less prevalent in Merthyr than in any place in England and Wales.' And he expressed his belief in the 'perfect salubrity of the vegetable food so grown.'

"With regard to the assumption which has been made that entozoic disease would be propagated by irrigation, all the evidence that the country has been able to collect, and more especially the positive facts obtained by experiments, are against such an idea; and the Committee is of opinion that such disease will certainly not be more readily propagated by sewage irrigation than by the use of human refuse as manure in any other way, and probably less if the precaution be taken of not allowing the animals to graze, but always having the grass cut and carried to them."—*Med. Times and Gaz.*, Sept. 27, 1873.

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*Marini's Anatomical Preparations.*—Among the most curious things at the Vienna Exhibition are the anatomical preparations of Dr. Marini, of Naples, showing how various parts may be preserved for years in an extraordinary manner. The freshness which a portion of, or a whole, subject may exhibit is astonishing. For example, a foot prepared at Paris in 1864, and bearing Professor Sappey's voucher, remained quite unaltered; and on making an incision into it the subjacent parts looked as fresh as those of a person just dead. The fatty tissue presents its ordinary aspect, and the tendons have their pearly lustre. The tissues, moreover, retain their transparency, and viewed in the dark before a light, their different layers and the position of the bones are distinguishable. By one of his processes Dr. Marini produces what he calls the "coriaceous" condition, in which the tissues are hard and without transparency, but on being placed in water recover all their freshness. A portion of such a preparation made in 1863, exhibited before the jury, had all the appearance of being part of a recent corpse. It will be remembered that at the Paris Exhibition of 1867, M. Brunetti obtained the grand prize for his preparations made by the agency of tannic acid; but these, although exhibiting the natural forms, were dry and hard. At present M. Marini keeps his procedure a secret. Another ingenious procedure is only employed for embalming and what he calls petrifaction. By this means Thalberg has been preserved in a "fresh" state for the adornment of his widow's drawing-room. That property of electricity has been utilized by which it transports certain salts, molecule by molecule, to one of the poles, and eliminates others, so that the tissues to their ultimate cellular terminations become penetrated with insoluble salts, while the general form is preserved. Signor Daffito, a former préfet of Naples, was recently so embalmed, and as it is a long process, Dr. Marini, in order not to have to go to the cemetery every day while it was going on, attached a small electrical bell, which sounded as long as the electrical current continued, desiring the keeper of the cemetery to let him know when it ceased ringing. The popular imagination became aroused, and it was asserted that the devil in person was ringing the confessional bell in the ears of the defunct préfet—he having died without extreme unction, and having had only civil burial."—*Med. Times and Gaz.*, September 6, 1873, from *Lyon Méaicale.*

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Obituary Record.—Died, in Paris, September 20, 1873, in the 66th year of his age, of heart disease, Auguste Nélaton, Surgeon in Ordinary to the late Emperor Napoleon, and one of the most eminent surgeons of the age. Dr. Nélaton held many honourable positions. In 1851 he was appointed Professor of Clinical Surgery, which he held until 1867, when he was made honourary professor. He was a member of the Institute and of the Academy of Medicine, Commander of the Legion of Honour, and was appointed by Napoleon III. a Senator.

——, September, M. Coste, Professor of Physiology in the College of France, in the 66th year of his age. M. C. is well known by his researches in embryology, and for his successful efforts in promoting pisciculture and astriculture in France.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on a Case of Pleurisy.* By GEORGE JOHNSON, M.D., Physician to King's College Hospital.

T. L., aged 16, an errand boy, was admitted under my care on June 18th. On June 9th, he left off his waistcoat, and in consequence, he got a chill. On the 12th, he first felt pain in the left side, of a dull aching character. The pain was increased by exertion and by a deep breath; and being unable to continue his work, he went home to bed. The pain continued; and he lost his appetite, and felt weak. On the 18th, when admitted into the hospital, the left side of the chest had a rounded form, the intercostal spaces bulged, and the ribs were nearly motionless. The left side measured 14¼ inches, the right 14 inches. The heart was seen and felt beating to the right of the sternum. The whole left side was dull on percussion from base to apex. No respiratory sound was audible, except an indistinct and distant blowing near the spine. Vocal fremitus was absent. On the right side, there were normal resonance and puerile respiration. Respirations 34; pulse 120; temperature 101.4; urine normal. The boy had a pale, delicate, and emaciated look, and a malar flush on the face. Here we obviously had to deal with a very copious liquid effusion into the left pleura; and, after watching the case for a few days, I determined, for reasons which I will presently explain, to have the liquid withdrawn.

On June 26th, the house surgeon, Mr. Duncan, introduced a fine canula through the ninth intercostal space in a line below the angle of the scapula, and drew off with an aspirator forty-one ounces of opalescent fluid. The wound was then closed, and no air was admitted into the pleura. The admission of air into the pleura, if it do not increase the risk of suppuration within the cavity, certainly tends to compress the lung, and so to impede, if not entirely to prevent, its expansion after the removal of the liquid. With-

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in a few minutes after its removal, the liquid formed a firm gelatinous coagulum. The withdrawal of the liquid was attended with immediate relief to the breathing.

Two days afterwards, the left side of the chest had regained its normal form and size, and its movement was nearly as free as that of the right. From that time his progress towards recovery was continuous and rapid; the normal resonance and respiratory sounds gradually returned; and last note of him, on July 21st, just before he left the hospital, was to the effect that the only remains of abnormal physical signs were some dulness on percussion and feeble respiration below the angle of the left scapula, the result, probably, of false membranes over that part of the lung.

Now, I wish to point out to you that there are two conditions which greatly impede the absorption of the serous effusion of pleurisy. These are, 1, so copious an effusion of liquid as to distend the pleural cavity; 2, a thick layer of unorganized fibrine covering the surface of the pleura. A very copious liquid effusion impedes absorption, partly by obstructing the flow of blood through the compressed lung, thereby causing a general fulness of the systematic veins, including, of course, the bronchial veins; partly by directly compressing the subpleural veins, thus retarding the return of blood, and causing capillary engorgement beneath the pleura. When the pressure of liquid is sufficient to cause bulging of the intercostal spaces, such as occurred in this case, it is obvious that the intercostal venous circulation must be seriously impeded. The mechanical withdrawal of a sufficient amount of the liquid effusion to relieve tension of the cavity and remove pressure from the lung, and the veins beneath the pulmonary and the costal pleura, will usually be followed by a quickened absorption of the liquid which remains in the pleura. In like manner, when anasarcous swelling of the legs has rendered the skin so tense as to impede the return of blood by the veins, and thus to favour the increase of the dropsical swelling, the discharge of some liquid through a puncture in the skin is usually followed by the absorption of a further portion of the dropsical effusion, which entering the circulation, exerts a diuretic influence upon the kidney, and excites a copious flow of urine.

There is no difficulty in understanding that a thick layer of fibrine covering the surface of the pleura, and therefore interposed between the subpleural vessels and the liquid effusion, must greatly impede the absorption of the liquid. In some cases of pleurisy, with copious liquid effusion, the pleura has been covered by firm unorganized fibrine from a quarter to half an inch in thickness. Now I wish to show you that an exact knowledge of the mode in which a thick layer of fibrine is formed upon an inflamed pleura affords a powerful argument for early tapping in cases of pleurisy with copious liquid effusion. The explanation which I am about to give you applies to the formation of false membranes upon the pericardium and peritoneum, as well as upon the pleura. In the first stage of inflammation, the serous membrane is roughened by a thin layer of exuded lymph; in the next stage there is an effusion, more or less copious, of an albumino-fibrinous liquid. Then the subsequent thickening of the false membrane on the pleura occurs by successive deposits of fibrine from the liquid effusion upon the previously exuded and deposited lymph. The process is exactly analogous to that which occurs on the surface of an inflamed cardiac valve. The endocardium being roughened by a scanty exudation of lymph, there occurs a subsequent deposit of fibrine from the blood upon the damaged valve, and thus the so-called warty vegetations are formed. The fibrine coagulates and is deposited upon any part of the endocardium which has been roughened by inflammation, as it coagulates and concretes upon a wire or other foreign body introduced within the vessels of a living animal.

The liquid effusion of pleurisy may be looked upon as blood minus its red corpuscles. We have seen that the liquid drawn from our patient's chest quickly clotted into a gelatinous mass; and this coagulation, which occurs rapidly after the removal of the fluid from the chest,

often takes place gradually within the chest, upon the roughened surface of the inflamed pleura. The explanation which I have given you of the process by which fibrine is deposited from the liquid effusion of pleurisy is in accordance with the fact that, while in cases of dry pleurisy the effused lymph is comparatively scanty, the very thick and firm false membranes occur only in association with a copious liquid effusion.

And now for the practical application of this pathological doctrine. It is obvious, that the longer the liquid effusion of pleurisy remains within the chest, the greater is the probability of a copious deposit of fibrine upon the roughened surface of the pleura, and the thicker this fibrinous deposit, the less is the probability that the liquid will be absorbed. These considerations, then, suggest the expediency of early tapping in all cases of pleurisy with a copious liquid effusion; and I have no doubt that the timely performance of thoracentesis in the case of our patient greatly promoted his recovery. If the liquid had not been pumped out of the chest, it is probable that the pleura would have become coated over by successive layers of fibrine deposited upon its surface; the result would have been a tedious convalescence, and ultimately an incomplete recovery, with more or less contraction of the side, the lung being bound down, and its expansion prevented by a thick and firm false membrane over its surface.—*Brit. Med. Journ.*, Oct. 25, 1873.

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### HOSPITAL NOTES AND GLEANINGS.

*Case of Spasmodic Dysmenorrhœa.*—Under the care of Dr. MATTHEWS DUNCAN, at the Edinburgh Royal Infirmary.

The following case illustrates very clearly the symptoms of the so-called mechanical dysmenorrhœa which, according to some authorities, is in almost every instance due to a flexion of the uterus. Whatever may be the frequency of flexion of the uterus (and it varies greatly with different practitioners), it is certain that this bent condition of the organ may sometimes cause painful and irregular menstruation; but it would appear from the evidence of good and unprejudiced observers that the part which a flexed uterus plays in the female economy has been greatly exaggerated.

M. H——, twenty-nine years of age, married for four years, has had no children, was admitted to ward 16 on the 26th of June, 1873, complaining of pain during menstruation. Patient is a strong-looking, stout, ruddy-complexioned female, and, with the exception of the complaint mentioned, enjoys, and has always enjoyed, good health. The dysmenorrhœa commenced when patient was sixteen years old—at which age menstruation began—and has continued without intermission ever since. The discharge is preceded generally by vomiting, and the pain accompanying it is of so severe a character that it necessitates her lying in bed for four or five days. The pain is referred by her to the hypogastric and lumbar regions, more especially the former.

July 4th. On vaginal examination during the day preceding a monthly period, nothing particular is discovered. On passing No. 9 of the series of uterine bougies (corresponding to the male urethral series), patient complains loudly as soon as the internal os is reached, and this number is as large as can be easily passed.

July 5th. Patient is menstruating to-day. No. 9 sound passes without pain. No. 12 bougie causes the same pain that No. 9 did on a former occasion. No. 14 was passed.

6th. The patient declares herself quite free from pain. No. 14 bougie goes into the cervical cavity quite easily.

14th. Has been quite free from pain since last report. She says that she has never had such an easy monthly period.

15th. Dismissed at her own request.

One case proves very little, but this is a good example of the use and efficiency of treatment by bougies. The success certainly astonished the woman very much. This case also illustrates very distinctly one branch of the argument against the mere mechanical character of this dysmenorrhœa, which is more justly called spasmodic. It was a characteristic case of what is called mechanical dysmen-

orrhœa. The internal os uteri was very sensitive, tender, and rigid, yet it easily passed a No. 9 bougie, indicating a passage of dimensions quite natural, and more than sufficient to transmit the menstrual flow. Moreover, in this case the state of the internal os during the flow was examined, and it was then found enlarged, not contracted; it then allowed a No. 14 bougie to pass easily. In short, with all the symptoms of so-called mechanical dysmenorrhœa, there was not only no obstruction, but more than usual enlargement of the passage of exit for the menstrual fluid.—*Lancet*, Sept. 6, 1873.

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*Ovariotomy; Drainage Tube passed from the Peritoneal Cavity through the Vagina.* —This case was treated at the Addenbrooke's Hospital, Cambridge, by Prof. Humphrey, and is reported in the *Lancet* (Oct. 18th, 1873). The subject was a widow aged fifty-two, admitted February 6th, 1873, who had been tapped twenty-one times. The abdomen measured five feet in circumference a little above the navel. The operation was performed February 7, under chloroform, by an incision four inches long, which was made as near to the pubes as possible, for the purpose of avoiding the region of the trocar punctures, where adhesions were most to be expected. The linea alba was carefully divided, but a gush of fluid showed that the sac had been opened. The fluid was allowed to flow away, and the sac was accordingly emptied. It proved to be adherent to the whole of the fore part of the abdominal wall, and some difficulty was found in tearing through the adhesions. This was, however, ultimately done, and the sac was removed without enlarging the incision first made, and with very little exposure of the contents of the abdomen. The pedicle was long. A clamp was applied. Two vessels in the pelvis bled briskly. These and four others on the inner surface of the abdominal wall were tied with catgut ligatures, which were cut off close to the knots. There was still oozing from many points into the abdominal cavity; accordingly, the precautionary plan suggested by Dr. Marion Sims was adopted. A trocar with canula was passed from the recto-uterine pouch of the peritoneal cavity into the vagina; a long perforated drainage-tube was then introduced through the canula, and the latter having been withdrawn, the tube was left, one end being brought externally through the vagina, and the other through the lower part of the wound. The two ends were secured by being tied together. The wound was closed with catgut sutures, and pads and bandage were placed on the abdomen.

After the operation there was no great amount of shock, neither did the temperature at any time exceed 101°. The looseness of the bowels, which existed before the operation, continued for some days. During the first three days a large quantity of sero-sanguinolent fluid passed through the drainage-tube. This stopped completely, and the tube was removed on Feb. 23d. The clamp separated on Feb. 25th. The external wound healed without trouble, and the patient recovered without any unfavourable symptom.

In another case, in private practice, since operated on, the same plan was adopted, and with like good result.

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*Modification of the Operation for Hare-lip.*—On two successive Saturdays Sir William Fergusson has recently demonstrated to the students of King's College, London, a novel modification of the ordinary operation for hare-lip. The cases in which he carried out this plan were of the usual type, the fissure being, as in the majority of instances, on the left side; and in both it was considered advisable to take away the intermaxillary bone. This adds to the success of the operation, not only by removing an occasional obstacle to primary union, but because the teeth, which are subsequently developed from the protecting knob, are worse than useless, by reason of their deficient development and faulty position. Instead, however, of removing the portion of bone readily with the knife or bone forceps, it had occurred to Sir William that it would be much better to operate subcutaneously, so to speak, by stripping off and retaining the mucous membrane; and accordingly this was done, with per-

fect success, the bone shelling out readily from its investment. Not only will this procedure greatly accelerate the subsequent process of healing, but the advantage is obvious, of retaining a thick and firm mucous surface in preference to the more artificial substitute of cicatricial tissue.—*Brit. Med. Journ.*, Nov. 1, 1873.

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*Prof. Esmarch's Method of Preventing Loss of Blood in Operations.*—Professor Esmarch, of Kiel, in a clinical lecture, gives a graphic account of an operation in which he employed, with complete success, a method for preventing the loss of blood in operations. The case was one of extensive necrosis of both tibiæ. While the patient was being brought under the influence of chloroform, a bandage of India-rubber webbing was applied tightly round each leg, from the toes to above the knee. Immediately above the bandage, a piece of India-rubber tubing was drawn firmly four or five times round the thigh, and its ends were secured together by hook and chains. This being done, the elastic bandage was removed from the leg, which was found to be quite exsanguine — in fact, like the leg of a subject on the dissecting-table. The operation for removing the sequestrum was then performed. So utterly bloodless was it—so entirely free from the oozing which often requires the aid of an assistant to clean the wound before the surgeon can proceed with his operation—that Dr. Esmarch was able to dispense altogether with the aid of an assistant. In fact, his ordinary assistant, Dr. Peterson, was at the same time operating in a similar manner on the other leg of the same patient; Dr. Esmarch having decided that, as he could save the patient's blood, he would also avoid subjecting him to two operations at different times, and thus spare him the tedium of two processes of convalescence. The operation having been completed and the wounds dressed with plugs of amadou and antiseptic applications (Dr. Esmarch being apparently a follower of Professor Lister's doctrines), the caoutchouc tube was removed, and the blood allowed to re-enter the leg. There was no hemorrhage—the whole amount of blood lost during the operation being about a teaspoonful from the bone. The subsequent progress of the case was most satisfactory; the healing process proceeding so rapidly, that the patient was enabled to leave the hospital, at his own request, on the twenty-first day after the operation.

This method is now being tried at most of the London hospitals, and is mentioned with strong approval by surgeons who have practised it. On the other hand, criticisms are not wanting; but these are mostly theoretical, and directed against detail; they do not attack the general principle. In fact, the essential advantage of the method—the prevention of hemorrhage — has been sought by thoughtful surgeons for years past—notably by Mr. Hilton of Guy's Hospital. When about to perform amputation upon an anæmic subject, Mr. Hilton was wont to have the limb bandaged for some minutes beforehand with an ordinary calico bandage, from its extremity to the part at which the tourniquet was to be applied. He then kept the bandaged limb elevated until the commencement of the operation. This proceeding is of considerable advantage to the patient, though it does not render the tissues so thoroughly anæmic as when Esmarch's elastic bandage is properly applied. But, besides this primary object, the saving of the patient's blood, which Prof. Esmarch's ingenuity has thus accomplished with a thoroughness never hitherto attainable, certain secondary benefits are secured to the operator and the patient. The deep parts of the wound are not obscured by escaped blood. Hence the operator suffers no interruption from the application of the sponges; his view of the structures bordering upon the line of incision is as unimpeded as it ever is upon the *post-mortem* table, and fewer assistants are required. In cases where it is necessary to distinguish healthy from diseased or dead tissues, as in operations for the removal of necrosed bone or of tumours, for the excision of joints, etc., the chief secondary advantages of the procedure are most apparent.

Esmarch's method has been employed

at Guy's Hospital twenty-four times. Nearly all the surgeons and assistant-surgeons have practised it since the first occasion of its employment during an excision of the knee-joint by Mr. Howse, on September 16. The 24 operations have been the following: For necrosis 12; amputations of the thigh, 3; amputations through the knee-joint, 2; amputation of the leg, 1; amputation of the arm, 1; excisions of the knee-joint, 2; excisions of the elbow-joint, 2; removal of exostosis from the first phalanx of the index-finger, 1. The following varieties in its use have been employed. In one case of secondary amputation through the thigh for compound comminuted fracture of tibia and fibula, no elastic bandage was applied, lest septic materials might be driven into the general current of the blood, but the India-rubber cord was simply used instead of an ordinary tourniquet. In another case of similar injury, a small bandage was first applied from the knee downwards to the fracture, then the larger elastic bandage from the knee upwards in the usual way. Again, in the case of the exostosis already mentioned, Mr. Durham first bound separately the index-finger and thumb with a narrow elastic bandage, and then included all the fingers and thumbs in the wider bandage, with which the limb was bound from the finger-tips up to the point at which the elastic cord was applied. At Guy's, an elastic cord or rope was substituted for the tourniquet, not the India-rubber tubing which is in general use.

In five of the seven amputations, the edges of the flaps have sloughed; one of the two which escaped the sloughing was the only one of the seven cases not amputated under the carbolic acid spray. For the removal of necrosed bone and excision of the joints, the advantage of the method has been most evident, as it was also in the case of removal of the small exostosis, before alluded to, where the presence of blood would have much increased the difficulty of the operation. —*Brit. Med. Journ., Oct.* 25 and Nov. 1, 1873.

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# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*Yellow Fever in New Orleans in* 1873; *its spread arrested by disinfectants.*—Dr. Alfred W. Perry, Sanitary Inspector of N. O Board of Health, states (*N. O. Med. and Surg. Journ.*, Nov. 1873) that yellow fever was introduced into New Orleans, July 4th, by the mate of a Spanish vessel from Havana, which arrived on the 26th June, and the disease then slowly spread. "During the first week in August the Board of Health commenced extensive disinfection with carbolic acid, of all places where yellow fever had been reported. The disinfection was performed in two different ways, viz., when a case of yellow fever was reported, all the yards, alleys, and drains in the square were sprinkled with carbolic acid, by hand sprinkling-pots; about 70 gallons of the carbolic acid were used per square. This was done to destroy any disease germs that might be on the ground, and to prevent the spread of the disease germs over the other parts of the same square. Thirty entire squares and twenty-one half squares where yellow fever had occurred were thus disinfected in the fourth district, and in only seven of these areas disinfected were there any subsequent cases of yellow fever."

The streets were also disinfected with carbolic acid by sprinkling water-carts. Nowhere in the world, he says, has disinfection on so extensive a scale been used. "In sprinkling the streets about 20 gallons were used to every 100 yards; this was repeated several times at intervals of five to ten days. The large amount of carbolic acid used made the air of a disinfected locality exceedingly irritating to the eyes, and sometimes produced headache and nausea. These disagreeable effects are due to the naphtha and naphthalene, which constitute the impurities in the crude carbolic acid; these have no disinfecting value, and in future a purer acid should be used, which is not very unpleasant and equally effective and cheap." He further says that a few cases occurred in Mobile, and the disease was extinguished by the same method.

*Death from Chloroform.*—A German, aged 44, was admitted into the Cincinnati Hospital on account of a dislocation of the shoulder. Chloroform was administered on a towel, to produce relaxation of the muscles with a view to the reduction of the luxation. The breathing became irregular, the chloroform was removed, and the respiration became normal. The pulse at this time showed no irregularity. The anæsthetic was again administered, and before the muscles were completely relaxed it was removed. Half a minute later, at the moment of reduction, the patient ceased to breathe. All efforts at resuscitation were fruitless.

At the autopsy "the blood was more fluid than normal." The left ventricle was contracted, the right relaxed but empty; the valves were healthy. A detailed report of this case will be found in *The Clinic* for October 11, 1873.

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*The American Journal of the Medical Sciences.*—At the Vienna Exposition for 1873, *The American Journal of the Medical Sciences* was specifically included in an award of a "medal of merit" to its publisher. This, so far as we know, is the only award made to a medical periodical.

—

*Bellevue Hospital Medical College.*—Dr. William A. Hammond has resigned the Professorship of Diseases of the Mind and Nervous System and Clinical Medicine and of Materia Medica and Therapeutics in this school.

Dr. Edward G. Janeway has been appointed Lecturer on Materia Medica.

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*Yale Medical School.*—Dr. David P. Smith, of Springfield, has been appointed Professor of the Theory and Practice of Medicine in this school.

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*Binghamton Asylum.*—Dr. Lyman Congdon, of Syracuse, formerly superintendent of the Willard Asylum, has been appointed superintendent of the Inebriate Asylum at Binghamton, vice Dr. Dodge, resigned.

—

Obituary Record.—Died, at Hanover, N. H., September 26, aged 78 years, Dixi Crosby, M.D., for thirty-five years Professor of Anatomy and Surgery in Dartmouth College.

## FOREIGN INTELLIGENCE.

*Carbolic Acid in Intermittent Fever.*—While MM. Déclat, Barrant, and others have reported that it is a means which never fails—succeeding in obstinate cases wherein quinia had been given in vain—Dr. Curschmann, of Berlin, reports (*Centralblatt*, September 6), as the result of numerous trials of large doses in well-diagnosed cases, that the acid is utterly worthless, succeeding in none of them; and he is lost in amazement as to how other observers have got their results.—*Med. Times and Gaz.*, Oct. 4, 1873.

—

*Black Sulphuret of Mercury in Asiatic Cholera.*—Dr. Socrate Cadet, Prof. of Physiology in the University of Rome, has communicated to us a letter giving the statistical results obtained at Udine, Italy, during the late epidemic of Asiatic cholera from the administration of the black sulphuret of mercury (æthiops mineral). These results *appear* to be most favourable. The medicine was given not only as a remedy for the disease, but also as a prophylactic. According to M. Tornadini, of all those persons at Udine who took the medicine as a prophylactic not one was attacked with the disease. Prof. Cadet, however, neglects to state the dose, or the modes of administration of the article, and we are thus left in the dark with regard to these most important points.

—

*Therapeutical Properties of Propylamine.*—Dr. Aissa Hamdy (*Brit. Med. Journ.*, Sept. 27, 1873), who has just been admitted into the Faculty of Medicine of Paris, has recently published a thesis entitled *Etude Clinique et Physiologique sur la Propylamine et la Triméthylamine*, and which consists of a serious and impartial inquiry into the nature of the above substances, which he pursued on clinical and scientific grounds. According to Dr. Hamdy, the propylamine of commerce is an alkaline solution prepared from herring-brine, and is composed principally of ammonia and triméthylamine, with very little propylamine in it. After having gone through the distinctive characters of propylamine, he passes in review the clini-

cal experiments performed with this substance, since those published by Awénarius and M. Dujardin-Beaumetz, who in France was one of the first who called attention to it. The author then relates the results of seven cases of rheumatism, treated either with the simple or the hydrochlorate of propylamine, the notes of which he took in Professor Béhier's ward in the Hôtel-Dieu, as well as in the wards of M. Roger at the Children's Hospital. These observations prove, says the author, that, if the new medicament is not a specific in articular rheumatism, it promptly relieves the pain and fever, and thus finally effects a cure. But this number, I fear, is not sufficient for sceptics to form any grounds of argument in favour of this substance; and I heard Professor Sée, a well-known therapeutist, remark at a public lecture lately that the cures announced by the partisans of propylamine were those that would have been effected by any other treatment, or even without any treatment at all, as, from what he could learn from the observations published, the propylamine was generally administered about the middle or near the decline of the attack. To form a just estimate, continued M. Sée, of the real value of any new remedy, it should always be given at the very commencement of a disease; and it is only after having observed its effects in some hundreds of cases, and not in sixes and sevens, that one might be better able to assign it a place in therapeutics. This applies particularly to rheumatism and to all affections that run a certain definite course which is natural to them. In short, after a close study of the chemical, physiological, and clinical properties of propylamine, M. Sée found that its effects are due to the presence of ammonia, in which case it would be far better to adopt the latter than the filthy stuff extracted from herring-brine.

—

*Turpentine as a Prophylactic against Poisoning by Phosphorus.*—The Prix Barbier of the Académie de Médecine has been this year awarded for an observation and plan of treatment first made by Dr. Letheby in the match factory of Messrs. Bell & Black, at Stratford. The dreadful diseases of the bones of the face to which match-makers are liable from the inhalation of phosphorus were successfully averted in that factory, by the suggestion of Dr. Letheby that the work-people should wear, suspended to the neck, a little open bottle containing the essence of turpentine. The vapours escaping suffice to neutralize the effects of the phosphorus. Dr. Audant, of Dax, had a patient who had swallowed a decoction of lucifer-matches with a view to suicide, and a draught of turpentine to hasten it. The turpentine, on the contrary, acted as an antidote, prevented the phosphorus from burning in the economy, and so obviated its deleterious effects. The Academy has accordingly awarded its prize to M. Audant and M. Personne, but not to Dr. Letheby, whose priority is, however, formally recognized by the reporter.—*London Med. Rec.*, July 2, 1873.

—

*Antineuralgic Snuff.*—The *Rivista Clinical di Bologna* mentions an antineuralgic snuff prescribed with success in cases of facial neuralgia, by Dr. Scriffignano. The base of the snuff is quinia, and its composition as follows: Citrate of quinia, ten grains, very strong; exciting snuff (tobacco), fifteen grains. The medicament is said to act almost directly on the diseased nerve through the ethmoidal thread of the nasal ramus of Willis's ophthalmic, a branch of the fifth pair.—*Lancet*, July 5, 1873.

—

*Hydrophobia from the Bite of a Cat.*—A marked case of this occurred (*Lancet*, Oct. 18, 1873) in Liverpool in the early part of October. A boy of nine, five weeks after the infliction of the wound, which had been cauterized and dressed, gradually became averse to the sight or mention of water, and died in great agony from a succession of convulsive fits.

—

*Cinchona in India.*—In a recent parliamentary paper it is stated that there are now 2,639,285 cinchona plants in the government plantations on the Neilgherry Hills alone, without counting those of private planters in this and other districts. The largest trees are 30½ feet high, and over 8 feet in girth round the trunk. The area covered by the plantations amounts

to 950 acres, and is being largely added to every year. The bark under cultivation is stated to be much richer in quinia and other alkaloids than the wild bark of South America. During last year 7295 lbs. of excellent bark were sold in the London market, while 65,688 lbs. were supplied to the local manufactory. This year 20,000 lbs. will be sent home.

—

*The Bibliography of Medical Science.*—We learn from the *Lancet* of November 1, 1873, that M. Pauly, Librarian of the Bibliothèque Nationale of Paris, has just published the second part of the work bearing the above title. The first part comprises the bibliography, biography, and general history of medical science. The second treats of the history of medical schools, corporations, and societies in France and abroad; and the curious history of the quarrels between physicians, surgeons, and apothecaries. The book contains, moreover, documents relating to the history of various parts of medicine, as anatomy, physiology, hygiene, pathology, and therapeutics, both as to general history and special accounts, chronologically and ethnologically considered; investigations as to the history of particular maladies, etc., all arranged alphabetically. The third part will be published early next year. As to the value of the work, suffice it to say that a copy of the first part was presented to the Academy of Medicine of Paris by the late Daremberg, and the second by M. Latour, the talented editor of *L'Union Médicale*, in both instances most eulogistically.

—

*"The Lancet" Jubilee.*—With the number for October 4, 1873, *The Lancet* completed the fiftieth year of its existence. The energy and talent of its founder, the late Mr. Wakley, enabled it to weather the severe storms which darkened its earlier career, and have given to it a position of influence and usefulness which is rarely accorded to any periodical. Age has served to develop the strength of *The Lancet*, and render it even more worthy of the patronage and support which, as one of the leading medical journals of Great Britain, it has for many years enjoyed.

Obituary Record.—Died, at his residence in London, on the 27th of October, the eighty-sixth anniversary of his birthday, Sir Henry Holland, Bart., M.D., F.R.S., D.C.L. Oxon., Physician in Ordinary to Her Britannic Majesty.

This eminent physician, author, and traveller was born at Knutsford, Cheshire, England, in 1788, and graduated in medicine at the University of Edinburgh, in 1811. He was appointed Physician in Ordinary to the late Prince Consort in 1840, and Physician in Ordinary to Queen Victoria in 1852. In 1853, he was created a baronet. He occupied the office of Vice-President of the Royal Society and of President of the Royal Institution. His second wife was Saba, daughter of Rev. Sidney Smith, Canon of St. Paul's.

Sir Henry's career was a remarkable instance of a man rising to eminence in his profession, whilst entirely abstaining from the routine usually leading to professional advancement. He was never connected with a hospital, and never held office in a medical society. For the last fifty years he occupied a prominent position in the polite society of England, and was on intimate terms with the many distinguished persons who mingled in it during that time.

As a veteran traveller Sir Henry was well known, having devoted two months of each of the last sixty years to travelling in foreign lands. On eight different occasions he visited America, and counted among his personal friends six Presidents of the United States.

Sir Henry is well known as the author of *Medical Notes and Reflections* and *Recollections of Past Life* (1871).

——, at Dublin, on the 20th of October, of cancer of the liver, Robert William Smith, M.D., Vice-President of the Royal College of Surgeons of Ireland and Regius Professor of Surgery in the University of Dublin.

Dr. Smith is well and favourably known to the profession of this country as the author of a *Treatise on Fractures and Dislocations*, which was published in 1847, and won for him an enviable reputation, and by his magnificent work on *Neuroma*, which was published two years later.

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THE

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on Umbilical Hernia.* By JOHN WOOD, F.R.S., Surgeon to King's College Hospital.

GENTLEMEN: During the last few months we have had a good many cases of umbilical rupture, both in the infant and adult. The frequency of this complaint, and the importance of dealing with it properly and at an early stage, will speedily be recognized by each of you when charged with the responsibilities of practice. And this consideration has led me to choose this for the subject of my remarks to-day. Now, there are two varieties of hernia which usually come under the denomination of umbilical. The most common, and the most curable fortunately, is seen in very young infants and children. The other occurs in adults, most of whom have been subjected to distension of the abdominal cavity from corpulency or pregnancy, or both combined.

The *infantile* form is invariably more or less *congenital* in its formation, although it may not show itself to a noticeable extent until after the lapse of some months or even years after birth. Even in these latter instances a careful examination of the cicatrix which is left by the drying up and dropping of the navel-string would reveal an imperfect closure of the fœtal opening, and perhaps a small protrusion at times when the infant cries. In order to understand its formation it is necessary for you to review the developmental changes which result in the formation of the placenta and umbilical cord and their differentiation from the fœtal portion of the ovum. At the beginning of the second

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month after conception the structure which ultimately becomes the umbilical cord is formed by the approximation and final connection of the two vesicular processes, originally quite distinct—viz., the *umbilical vesicle* and the *allantois sac*. The former contains the yolk or early nutriment of the fœtus, and is connected by a canal—the *omphalo-enteric duct*—with the intestinal tube at the place where afterwards the ileo-colic valvular apparatus is found. The straighter part of the intestine below the point of connection becomes afterwards the colon, with its vermiform appendix. The part nearer to the stomach becomes developed into the coils of the small intestine. These latter during the second month protrude into the substance of the cord for a considerable distance beyond the point where its highly elastic and gelatinous-looking substance becomes continuous with the abdominal wall of the fœtus. On the stomach side, or above these coils, the omphalo-mesenteric vessels pass from the umbilical vesicle to join the proper mesenteric vessels of the fœtus. Below them are the placental arteries accompanying that part of the allantoic duct which forms the urachus: above these, and passing at this early stage almost directly backwards, is the umbilical vein on its way to the liver.

As development progresses, the coil of small intestines which is found at first in the interior of the umbilical cord becomes gradually withdrawn into the enlarging abdominal cavity, and the supplemental pouch of quasi-peritoneum formed within the hyaline substance of the cord becomes aborted, and finally obliterated. From this time the umbilical opening is occupied by the enlarging umbilical arteries and vein with the gradually dwindling urachus.

Thus the navel must be considered as a sort of double cicatrix, the upper portion of which is formed by the vessels of the umbilical vesicle, and the lower division, which becomes later on the chief constituent of the navel, is occupied by the placental vessels and urachus. Between these lies the pouch formed in the substance of the cord for the primary development of the folds of the small intestine. This arrangement you will find well demonstrated in a specimen of an ovum in the collection of Dr. Sharpey (published in Miller's *Physiology*, Baly's translation, 1843, second edition, vol. ii., pl. iii. and iv.). If, however, the complete development of the infant is from any cause retarded or rendered irregular, this pouch of the navel-string may be to some extent persistent at the time of birth, just as the canal of Nuck may be in the groin.

In examining the bodies of prematurely still-born infants, I have found this pouch extending into the navel-string to the extent of half an inch. By the first struggles of the child, or by the pressure made upon its abdomen in parturition, the bowel may at once appear as a protrusion within the cord, constituting the so-called *hernia of the umbilical cord*. In such cases that portion of the cord which covers the hernial sac does not shrivel like the rest, but assumes, in discharge of its continued functions, more or less of the appearance of the surrounding skin. In cases where the pouch remains, but no actual rupture is present, the portion of navel-string which invests it becomes enfolded in the cicatrix, which is wrinkled and inverted by the contraction of the umbilical vein and arteries, so as to form a larger, more puckered, and deeper depression than normal. This may afterwards become protruded and distended under the pressure of the abdominal viscera, and form that kind of umbilical hernia which appears directly or soon after birth. In all these cases the membrane which is technically called the peritoneal sac at this point is exceedingly attenuated, and in some instances hardly demonstrable. It is an imperfect formation, and for practical purposes may be esteemed non-existent. It is so adherent at the edges of the opening to the aponeurotic structures that it allows of no dragging or displacement of the surrounding portion of serous membrane, and the tension to which it is speedily subjected spreads it out into a very open mesh of tissues, having but slight resisting power in itself. I have seen several cases in which the tube of the urachus also remained pervious after birth, and exuded urine (sometimes in considerable quan-

tities) in the exertion of crying or micturition.

Practical accoucheurs usually warn the student against tying the navel-string too close to the body of the child, for fear of including in its grasp a loop of intestine which might be present in a hernia of the umbilical cord. But it seems to me that the opposite habit of extreme caution in this respect leads to the application of the string at such a distance from the body that a portion of the root of the cord containing a tubular pouch may still remain, and leave a weakness at the part predisposing to a future protrusion. Thus it is not closed, as it might easily be at this time by placing the ligature closer up to the abdominal wall. Of course care should be taken in doing this that any intestinal contents should be pressed out of the cord; and this is best done by pressure with the fingers, and then giving the cord a gentle twist on its own axis before applying the string.

The formation of so-called umbilical hernia later in life in adults who have a tendency to corpulency usually differs considerably in its pathology from that of the infant. A close examination will usually show that the opening into the abdominal cavity is placed in the linea alba, above, below, or to one side of the real navel. As the tumour increases in size, and the skin is distended over it, the navel becomes drawn over it so as to appear to form its point of departure. In the larger cases the bulk of the tumour is found to be below this point, and the part where the edge of the hernial opening presses most acutely and forcibly upon the contents, and most commonly strangulates them, is at the lower border. The weight of the protrusion itself increases this effect, and tends to bring the tumour lower on the abdomen as it increases in size.

The linea alba is perforated more or less regularly by branches of deep and superior epigastric vessels and twigs of nerve forming the terminal distribution of the intercostals. As the individual grows fatter, the adipose tissue is apt to form in masses extending along these vessels from the subperitoneal fat. The tendinous apertures lodging them are also under these circumstances frayed out by over-distension, and gradually become enlarged. If at this time, by illness or sudden alteration of habits, as after parturition in females, the fat is absorbed or the tension relaxed, a protrusion of omentum behind the peritoneum pushes forwards that attenuated membrane, and forms the sac of an incipient rupture, which may speedily increase under the effects of a bronchitic cough or the straining of constipation or of defecation. As a rule, while the umbilical rupture of children hardly ever contains omentum (which is at this age very scanty and imperfectly formed), but usually includes small intestine only, the rupture of adults almost always contains omentum, sometimes much thickened and hypertrophied, and may contain a portion of colon instead of, or in addition to, small intestine. In very large cases even a portion of the pylorus and duodenum may be involved, giving rise to distressing irritation of the stomach. I have seen many hernial protrusions, both in the child and in the adult, in the linea alba above the umbilicus, somewhat about midway between it and the xiphoid cartilage. At first, these are always formed of lobules of subperitoneal fat, sometimes constituting quite a fatty tumour, which has a distinct impulse on coughing, and can be pressed inwards to a certain extent, but never completely reduced. In after years these may certainly become developed into renal herniæ, with a peritoneal sac containing bowel. Usually, with a little care in treatment, this may be prevented, since the opening is placed above the reach, as it were, of the small intestine, and is protected by the apposition of the liver and its round ligament.

The *diagnosis* of the umbilical herniæ of children is seldom difficult. Carcinomatous or other growths from the site of the navel-string may occasionally appear in early infancy, and receive a doubtful impulse in coughing. Their consistency, unyielding bulk, unvarying nature, and steady growth, will usually suffice to distinguish them. Chronic peritoneal abscesses may cause more difficulty. These make their way to the umbilicus, guided

by the superior ligament of the bladder or round ligament of the liver, and in their earlier stages closely resemble umbilical rupture. They yield to pressure, and may be entirely pressed back into the abdominal cavity, and give a distinct cough-impulse. The previous history of abdominal inflammation or enlarged glands, the constitutional hectic, and afterwards a fluctuation felt in the tumour, will sufficiently distinguish them even before their final discharge of pus. An imperfectly closed urachus may also simulate umbilical rupture. Cases have been known in which small urinary calculi have been thus voided.

The herniæ of adults are most likely to be mistaken for subcutaneous fatty tumours; and, indeed, many of these supposed ruptures consist really of a fatty growth from the subperitoneal tissues protruding through the apertures before described. Though sometimes yielding a sort of impulse, and so simulating a real omental hernia, they are usually found destitute of a true cough impulse, by reason of adhesions at the tendinous opening and other consolidating changes. *Hydatid cysts* may also be found in this situation.

The *treatment* of umbilical rupture in the child is fortunately very powerfully aided by the persistent tendency to a more perfect development which prevails after as before birth. If observed early and treated skilfully, these protrusions may usually be cured by the second or third year, and frequently in much less time. The protrusions of fatty lobules from the subperitoneal fat, however, are much more slow to disappear both in the child and adult. In these the chief care should be directed to prevent a rupture from succeeding them if the fat becomes absorbed, which may result from the intervention of some acute disease or anything causing the general removal of adipose tissue. Continued pressure will also accomplish this result, if carefully applied and maintained. In some cases I have removed these growths with the knife with success, and without the occurrence of peritoneal mischief. It should be borne in mind, in dealing with any kind of tumour about the linea alba, that it may be deeply and closely connected with the peritoneum, and may arise from pathological changes occurring in these fatty peritoneal outgrowths.

The readiest way of applying pressure to the umbilical ruptures of children is by means of a common strapping placed over a flat piece of lead or pewter, or, what is usually more at hand, a penny piece. This should be first inclosed in folds of strapping applied with the sticking side outermost, so as to adhere to the skin over the tumour. Over this broad strips of soap or adhesive plaster should be placed across the entire abdominal surface, and surmounted by a belt or bandage. This, though a valuable temporary expedient, can with difficulty be long maintained, on account of the constant trouble of changing, the liability to soreness and irritation of the skin, and a certain degree of skill which is demanded for its proper application. Very cheap and efficient appliances are now made by the surgical apparatus manufacturer, consisting of a broad belt of India-rubber, on the under surface of which is placed a pad for application to the protrusion. Some of these, however, I must warn you, are based on false principles, and, if they do anything at all, are apt to do injury instead of good. The difficulty experienced by the maker is to make the pad keep its place, and in order to effect this a convex or conical protuberance is placed within the hernial aperture like a cork in a bottle. Now, if this is effective in maintaining its position, its action necessarily is to accomplish a dilatation of the yielding borders of the ring, and thus to perpetuate and increase the rupture. If inefficient, it slips out of the aperture, and affords no resistance to the escape of the bowel; the only result being a dangerously false security.

Some years ago I devised a pad, consisting of an India-rubber ring adapted to the size and shape of the edges of the opening, which should press only on the edges, with the same tendency to close them as by pressure with the fingers in reducing the protrusion. The central aperture is covered over by a tense drum-like layer of India-rubber, which affords

resistance to protrusion indeed, but produces no invaginating pressure. A figure of this umbilical pad is given in my work *On Rupture* and also in the last edition of *Druitt's Vade-Mecum*. Latterly, Messrs. Matthews have modified this pad by an ingenious arrangement of air-pressure in the apparatus I show you. The ring pad itself is made into an India-rubber air-cushion, with a small aperture of communication into a globular air-chamber made of a thinner substance of the same material, and placed within the opening of the ring. Under ordinary pressure the projecting outline of the ring presses only upon the edges of the hernial opening, but under sudden succussion—as by a cough or laugh—some of the air is forced into the central globular cushion, and protrudes it, so as to meet the advancing rupture, and force it back by an elastic rebound resulting from the same impulse which tends to force out the rupture. For certain cases this is decidedly an improvement. All this is aided by the elastic reaction, also, of the India-rubber belt which maintains the pad in its place. This should be broad enough to keep well in position, and may advantageously be fastened by loops to the dress of the child to prevent its shifting round, as it is apt to do in its fidgety movements. A free use of violet powder or starch will aid in preventing chafing.

In cases of fatty peritoneal growths a perfectly hard and flat pressure, as by a plate of metal or ivory, is the most likely to do good and cause the absorption of the tumour.

In umbilical rupture in the corpulent adult less hope can be entertained of a cure, but much comfort can be insured by a proper belt. This should be broad enough to cover the abdomen almost entirely, with elastic material at the sides, a lace up the back, and kept from rucking up by whalebone ribs. Additional power may be obtained by a strap over the lower part of the protrusion, buckling at the side, and adapted to counteract the tendency to increase downwards and forwards in these cases. If the hernia be entirely reducible with comfort to the patient, an umbilical pad like those just described will be sufficient. But in many instances either a portion of the omentum or bowel remains permanently irreducible, or, if reduced, makes the patient feel so uneasy that it is impossible to maintain it in this situation. In such cases a concave or hollow pad is indispensable. It should have a raised, rounded rim or border of some soft and elastic material, as India-rubber, and should be based on and supported by a shield of thin copper or other metal of the same shape to protect the protruding mass from accidental blows or injury from the clothing. In large cases, in corpulent people with pendulous bellies, the whole belt should be maintained in place by shoulder-straps, or even a perineal band or thigh-slop may be required.

The limits of this lecture, gentlemen, will not allow me to revert to operations which are sometimes required for the relief of umbilical ruptures, which I must accordingly reserve for some future opportunity.—*Med. Times and Gaz.*, Nov. 29, 1873.

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## HOSPITAL NOTES AND GLEANINGS.

*Operation for Removal of the Female Breast by means of India-rubber Ligatures.*—At University College Hospital, on Nov. 21, Sir Henry Thompson performed an operation upon the female breast, which, so far as we are aware, is perfectly new to surgical practice in England. Previous to the entrance of the patient to the theatre, Sir Henry stated that the plan he was about to adopt had been brought recently under his notice during a visit to Vienna by Professor Dittel. An accident, as it were, suggested the treatment to Prof. Dittel, who now for some time has employed it in over 200 cases, such as of tumours of the breast, in removing the testes and even limbs, and in the cure of fistula in ano. Having been called upon to see a young girl dying from meningitis, the following account of the case was given him: The patient, who had been constantly reproved by her stepmother on account of the untidy state of her hair, was advised, some weeks before her death, to get a tightly-fitting net for her head, and to wear it night and day. This she did till the last, when it was found that

the elastic band of the net had cut its way through the scalp and cranium, and was resting on the meninges of the brain, fatal inflammation of which it had set up.

The immense power for effecting the solution not only of the soft tissues of the body, but even of bone, having, by the constantly contracting pressure of an elastic band, been thus so remarkably proved, Professor Dittel resolved to attempt in certain cases to substitute this power for the knife in surgical operations.

The application of the treatment to the mammary gland by Sir Henry Thompson we will now describe: The patient, a woman of about fifty-three years of age, had for ten years been conscious of a tumour in the right mamma. When first noticed it was seated near the nipple, below and to its outer side, and was of the size of a walnut. As it was discovered about the time of her confinement with her last child, which died soon after its birth, she was led to regard the tumour as a "distended milk-duct." It has gone on increasing, however, though very slowly, and about eight weeks ago the skin covering the tumour commenced to ulcerate. At the time of the operation the histological characters of the tumour were doubtful. It was of the size of a large orange, ulcerated on the surface, somewhat pendulous, and freely movable upon the adjacent tissue. The patient was a robust and healthy-looking woman. Chloroform having been administered, Sir Henry drew the mamma forward from off the pectoral muscle, and then, with a very long, strong, and slightly curved Liston's needle transfixed the submammary tissue. Through the eye, near the point of the needle, a long piece of very elastic India-rubber tubing, about the thickness of stout whipcord, together with a long silk ligature, was passed. The elastic ligature was then divided, and the needle withdrawn. Each half of the elastic ligature was tied very tightly, so as to embrace one-half the mamma, inclusive of the skin. In fastening the elastic ligature a piece of silk ligature was placed at right angles to the elastic between the skin and the knot, and while the single knot was tightly drawn, the silk was tied around it by an assistant to prevent it slipping. A double knot was then made, and this was secured by again tying the silk around the elastic.

The long silk ligature which had been passed with the elastic tubing through the submammary tissue was then removed. The purpose of passing this was precautionary, in order that another piece of elastic might be drawn along the same track in the event of either half of that which was first passed breaking. Another precaution very necessary to take is to hold the elastic firmly at the time of dividing it and while withdrawing the needle, otherwise the contractility of the tubing will cause its disappearance through the track made by the needle.

The time likely to ensue before the entire separation of the breast is eight or nine days. The pain excited during any portion of this time is remarkably slight. Sometimes a little pain is suffered for a day or two. In the case of the patient now referred to, there was no pain after the first twenty minutes from the time of recovery from the chloroform, and the suffering during this brief period was not at all severe.—*Med. Times and Gaz.*, Nov. 29, '73.

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*Nephritic Abscess opened from the Back* — The patient was a careworn-looking man aged fifty-four, who was admitted into St. Bartholomew's Hospital, under the care of Dr. Southey and Mr. Thomas Smith. For over ten years he had suffered from stricture of the urethra, for which tapping through the rectum had been performed some years ago. The patient for the last four or five years had neglected to pass his catheter, and had during that time suffered from great pain in the left renal region.

On admission into the hospital, on the 9th of August last, he suffered from occasional severe rigours, and had a constant severe pain in the left renal region, running down the left thigh as far as the knee. The pain was increased by extending the thigh, which was kept flexed on the abdomen, or by the act of defecation. The urine was thick, and contained from a quarter to a third of pus. A large fluctuating swelling was detected in the

region of the left kidney. There was apparently no history of renal or vesical calculus. The case was, however, diagnosed by Dr. Southey and Mr. Smith as one of renal abscess, in which there was probably a calculus or clotted pus preventing free escape down the ureter into the bladder.

On Monday last, the 24th instant, Mr. Thomas Smith had the patient put under the influence of chloroform, and then made an incision in the left lumbar region, as for colotomy. After dividing the latissimus dorsi muscle, he passed a director through the matted tissues into the fluctuating swelling, and let out about a pint and a half of thick, dirty, fetid pus. The pus came away per saltum at each inspiratory act, and towards the end it was found to be much clotted. The cavity from which the pus came was so large that the finger could not be made to touch every side, but no calculus could be detected by digital examination.

Up to the present time the case has progressed favourably. At a future time we shall complete the notes.—*Lancet*, Nov. 29, 1873.

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*Transfusion in Cholera.*—Dr. Stadthagen, Physician to the Shed Hospital at Moabit, Berlin, communicates (*Berlin. Woch.*, Sept. 22) a case of cholera in which he performed transfusion with success. The patient, a woman 29 years of age, was brought to the hospital on August 26 with her two children, her husband having died shortly before of cholera. Prodromic diarrhœa had set in the day before, and during the night had become excessive and watery, and was soon accompanied by vomiting. On her admission at 10 A. M. she exhibited all the signs of a commencing collapse. Her skin was flaccid and cold to the touch, and the face and extremities were covered with cold sweat. The thermometer stood at 36° Cent. in the axilla, and 38° in the anus. Folds of the skin only slowly recovered themselves. Pulse 90, and small. The abdomen was flattened and fluctuating to pressure, but nowise tender. The abundant stools had the characteristic rice-water appearance, as had the matters which were vomited. Great thirst. From time to time there were cramps, and the patient complained of a sense of constriction of the chest and of painful pressure at the epigastrium. In spite of all means employed, the collapse continued to increase, and when seen at 8 P. M. the change in her countenance told plainly of the extremity which she had reached. The extremities and lips were cyanotic, and the pulse and second sound of the heart could no longer be perceived; the temperature, too, had sunk to 35.4° in the axilla, and 37° in the anus. No urine had been passed for fifteen hours, and the stools came away unconsciously. In consequence of this condition of the patient, and of the great mortality that had attended the commencement of this epidemic, a very bad prognosis was delivered, and it was determined to have recourse to transfusion. About 180 grammes of defibrinated blood were injected into the median basilic vein by means of Uterhart's syringe. The operation was performed without any obstacle, the patient being scarcely sensible of it. While the blood was being propelled, the pulse, which had almost disappeared, could again be plainly perceived. An equable diffusion of bodily heat was also sensible to the hand, the peripheric parts therefore having had their temperature much raised. One hour afterwards the temperature was 36° in the axilla, and 37° in the anus; the appearance and general feeling of the patient undergoing corresponding improvement. At first several stools and vomiting of colourless matters still continued, but gradually diminished in number, and then assumed a bilious colour. The reaction, though slow and delayed during several days, yet met with no disturbance, the diarrhœa and nausea continuing for some time. The temperature during the three following days varied from 36.2° to 36.8°, and only on the evening of the fourth day reached more than 37°. Some highly albuminous urine was first passed after three days of anuria, and the first solid stool took place on the tenth day. The woman was discharged well on September 7.

In a second case the operation was tried without a good result. The patient, thirty-four years of age, had been passing rice-water stools for fifteen hours, and all the cholera symptoms were developed in a high degree. Neither the pulse nor the second sound of the heart could be perceived. During and immediately after the injection of blood the pulse could again be felt, and there was a temporary amelioration in other symptoms. The patient, however, died twenty hours after the transfusion.—*Med. Times and Gaz.*, Oct. 18, 1873.

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*Axillary Aneurism, Compression, Cure.*—Axillary aneurism, though rare, is always of serious import, as spontaneous cure is almost unknown, and the results of surgical interference have not hitherto been very satisfactory. The operation for the ligature of the third part of the subclavian for aneurism of the axillary artery is frequently attended with great danger, or is followed by such fatality that it would hardly be justifiable if other and safer means could be shown to exist. Syme's treatment is evidently unsuitable for the majority of axillary aneurisms. Compression alone therefore holds out a hope of success. But mechanical compression is generally difficult and painful, and compression of the fingers can only be systematically carried out where there is a large staff of students or assistants. Up to the present time there are not more than five recorded cases of the cure of axillary aneurism by compression; of these only two were cured by digital compression. In the case of a man aged 71, admitted into University College Hospital June 16th, 1873, under the care of Mr. Erichsen, compression was applied altogether for 25 hours, digital compression for 11 hours, and mechanical for 14.—*Lancet*, Nov. 15, 1873.

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*Treatment of Salivation by Atropia.*—The patient, a woman of sixty-eight years, had had two attacks of apoplexy followed by hemiplegia of the left side. On being admitted into Dr. Ebstein's wards (Breslau Hospital) profuse salivation was observed. According to the patient it had begun a month previously. Atropia was administered internally without any effect. On the dose being increased, the quantity of saliva diminished. Atropia (the sulphate) was then injected hypodermically, and after seven minutes the salivation was stopped. On doubling the dose the secretion was arrested for twelve hours. Dr. Ebstein explains the action of the drug through its influence on the permanent irritation of the secretory fibres of the salivary glands.—*Lancet*, Nov. 1, 1873.

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*Fecal Accumulation.*—Mr. T. Cole relates (*Brit. Med. Journ.*, Nov. 29), the following case of this: Mr. S., æt. 60, had been ill for two years, with gradually increasing distension of the abdomen, accompanied by some emaciation, loss of appetite, much flatus, and confined bowels. On examination, I detected an immense tumour filling the whole of the abdomen, except a small portion of the left lumbar region, where there was tympanites. It passed upwards under the ribs, downwards into the pelvis, was perfectly smooth, very hard, and quite immovable; over a small part, to the right of the umbilicus, was indistinct resonance; and somewhat below this, I felt a coil of small intestine between the tumour and abdominal wall, evidently filled with fecal matter. By firmly pressing the finger against the swelling, at different parts, I found that a slight indentation was made, though with difficulty. The superficial abdominal veins were much distended. The rectum was full of large hard lumps. My diagnosis was fecal accumulation to an extent I never saw or heard of before. Large injections of warm water daily for three weeks, aided by small doses of belladonna and nux vomica, brought away a most astonishing quantity of fecal matter, and resulted in the total disappearance of the tumour, and the restoration of the patient to perfect health. I may add, that homœopathy had had a lengthened trial in this case.

# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*Guarana for the Cure of Sick Headache.* By T. P. Caillouet, of Lockport, La.

MM. Trousseau and Pidoux, in their *Traité de Thérapeutique et de Matière Médical*, describe the mode of using the guarana powder in sick headache, and since the year 1861 I have used it with complete success in all patients who have applied to me for relief for the above mentioned malady. I did not use the extract recommended by Prof. Trousseau, but gave the powder in doses of ten to fifteen grains, repeated every two hours, and the patients rarely took three doses before they were relieved. A ten-grain dose taken immediately before the attack always prevented it.

Some of my patients, who suffered every month from sick-headache, were entirely rid of their sufferings for several months, and some for one and two years, after using one or two boxes of the powder, each box containing a dozen packages of ten grains each. I recommended my patients to take a dose (of the guarana) as soon as they felt any symptoms of an attack coming on; during the attack a dose every two or three hours until relieved.

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*Carbolic Acid in the Treatment for Tapeworm.*—Dr. J. H. Bill reports (*Medical Record*, Nov. 15, 1873) the case of a man suffering from tapeworm, who had taken in turn without relief the usual anthelmintics. The idea struck Dr. Bill, that if small quantities of "carbolic acid" are so pernicious to leeches, is it not probable that the drug might be used against a tapeworm. Accordingly, having purged the patient, I administered six grains of "carbolic acid" in a half-pint of water, four times a day. After two days of this treatment, as only a few joints of the worm had been voided, I changed the vehicle from a liquid to a pill form. Powdered extract of liquorice was used, and each five-grain pill contained two grains of "carbolic acid;" of these the man took one every hour, and a purge of rhubarb and jalap every morning. He soon began to pass large fragments of the worm, and on the third day the head and about four feet of the body of a tænia solium. He had taken thirty-five pills without inconvenience of any kind. He got well quickly, has remained well since, and I am satisfied is cured. I have since thought that the pills would have been improved by a delicate coating of paraffine; the object being, of course, to cause the pill to pass through the stomach unchanged into the intestine, carrying with it the "carbolic acid" in direct contact with the worm.

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*Frequently recurring Epistaxis relieved by Ergot, after Local Treatment had failed.*—Dr. Andrew H. Smith, of New York reports (*Med. Record*, Oct. 15, 1873) a case of this occurring in a civil engineer aged thirty-seven, who was of a rather delicate organization, and performed an excessive amount of mental labour. No abnormal condition of the nasal mucous membrane, except that the portion covering the septum on the left side was for a part of its extent unduly red.

A variety of astringents were applied locally by means of both the brush and the syringe, and such general treatment was resorted to as the symptoms demanded. This course was followed persistently for two weeks, when the general health had somewhat improved, and the congested appearance of the nasal mucous membrane, as far as open to inspection, had disappeared. Still the hemorrhages recurred as frequently as ever, being often apparently provoked by the very applications intended to prevent them.

I then prescribed the fluid extract of ergot, twenty drops to be taken three times a day. This was continued for ten days, with the effect of entirely restraining the bleeding from the time the first dose was taken. The medicine was then omitted, but in a few days the bleeding began anew. It was immediately arrested by a return to the medicine, and has not since returned, the drug being continued at gradually increasing intervals for nearly a month, when it was entirely discontinued.

*Disease of the Knee-joint; Amputation.*—At the clinic of the Massachusetts General Hospital, Dr. BIGELOW amputated just above the knee for disease of the joint. Before operating, he directed that the limb be tightly bandaged from the toes to the hip; after the tourniquet was applied, the bandage was removed. By this proceeding, the amputation was what might be termed a dry one; the blood which is commonly lost being saved to the patient. For twenty years, this practice has been followed at this hospital in amputations, excisions, necrosis, and removal of tumours in both the upper and lower extremities, in short, wherever it was desirable to save the blood of a feeble patient, or to facilitate dissection, as in the removal of a needle from the hand. In alluding to this long-established practice, Dr. Bigelow remarked that this expedient is occupying at the present time considerable attention abroad, both of the surgical public and of the medical journals. He believed that Esmarch's modification of this compression, by the substitution of an elastic rubber bandage, would soon fall into disuse; first, because a common bandage is effectual; second, because the majority of amputations are done by practitioners to whom such a bandage is inaccessible; and, third, because the material loses its elasticity in a few months. The same remarks apply to the circular elastic compression of an artery, which has been repeatedly tried in this hospital. If one turn of an elastic bandage exercises a pound pressure, it is plain that twenty turns will compress with a force of twenty pounds. But a common tourniquet will do this, and the modification of Signorini's tourniquet habitually used in this hospital insures, after removal of the compressing bandage, a dry amputation. This case also illustrated another point of current interest. The pulse being very much reduced by protracted disease, and the joint painful upon motion, exceptional care in etherization was needed as well for the patient's safety as his comfort. Instead of being brought to the etherizing room which adjoins the operating theatre, as is usual, the patient was carefully etherized in his bed before leaving the ward.—*Boston Medical and Surgical Journal*, November 27, 1873.

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*Notes of Practice at Roosevelt Hospital, New York.—Plaster-of-Paris Splints.*—Plaster-of-Paris is most commonly employed where a fixed apparatus for retention is required. In the application of these splints, rollers made of the ordinary mosquito netting are employed instead of the muslin bandages; the advantages claimed for the netting being, that more plaster can be carried in its meshes, hence a lighter and more delicately formed splint can be obtained, with equal firmness, than by the old fashioned method. The netting also is sufficiently elastic to permit its perfect adaptation to the inequalities of the limb, without reverses or wrinkles in the bandage. This is a very elegant method of applying the plaster-of-Paris splint.

*Synovitis.*—The treatment for synovitis consists of rest, ice-bags, perhaps leeches, and anodynes if necessary. In subacute and chronic synovitis, with joint filled or partially filled with fluid, the best results are obtained by the use of sponges and a firm roller-bandage.

In this hospital, where constant pressure and fomentation are desired, the hot sponges are the agents most commonly employed, and they serve a most excellent purpose. This is also the usual method of treating sprains. Apply about the joint, as soon as possible, sponges which have been wet in hot water, and secure them by a snugly applied roller-bandage. After they are firmly secured, they may be wet again. Change every twenty-four hours.—*Medical Record*, Oct. 15, 1873.

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*Nephrotomy.*—Dr. J. H. POOLEY has sent to the *Medical Record* (Oct. 15, 1873) the following memorandum which he found in a rather scarce book called "Mems., Maxims, and Memoirs, by William Wadd, Esq., F.L.S., Surgeon Extraordinary to the King. London, 1827."

"Mr. Paul, a surgeon at Stroud, in Gloucestershire, lately extracted from the kidneys of a woman, by an incision through her back, a rough stone as large as a pigeon's egg, and made an entire

cure; it is the first of the kind over performed in this kingdom.—*Gent's Magazine*, Aug. 1783."

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*Death by Chloroform.*—In the *Boston Medical and Surgical Journal* for Nov. 20 and 27, there is reported the death of a lady to whom a mixture of chloroform and ether had been administered by inhalation prior to the extraction of a tooth. The jury rendered as their verdict that "her death was caused by the inhalation of chloroform administered in a mixture of chloroform and ether by the said Dr. Eastham. The jury use this opportunity to caution the public against the inhalation of so dangerous an agent as chloroform for the production of insensibility to pain. In the opinion of the jury *the inhalation of sulphuric ether is safe, while the inhalation of chloroform, either alone or mixed, is always attended with danger.*"

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*Comfort for Philadelphia Tax-payers.*—Mr. Lewis W. Leeds of New York, to whom was awarded the premium for a "sunned and aired School-house" at the late Vienna Exposition, thus speaks of Philadelphia's new Public School-houses in an article published in the Dec. No. of the *Sanitarian.*

"Still worse than this is the plan of a large number of splendid brown-stone buildings that have been recently erected in Philadelphia.

"Of all the outrages on common sense, to say nothing of sanitary knowledge, that have been committed in school-house buildings for the last twenty years, these excel. Here, added to the great sin of massing all the collecting rooms together, is the still worse blunder of cutting off so large a portion of the light and air by the stairs, committee rooms, and *water closets.* These are splendid new buildings, for which millions of dollars of the people's money have been spent, and in which their children will undoubtedly be tortured for many long years before they will have the courage to do what they ought to do at once—*tear them down.*"

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*American Public Health Association.*—This useful Association held its second annual meeting in New York city Nov. 11, 1873. Dr. Stephen Smith, the President, opened the session by a brief address, explanatory of the importance of the work undertaken by the Association and the results which may be anticipated. A number of interesting papers were read, and after the transaction of the usual business the Association adjourned, to meet in Philadelphia on the second Tuesday of November, 1874.

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Obituary Record.—In our preceding No. we announced the death of Dr. Wilmer Worthington, of West Chester. At the stated meeting of the Chester County Medical Society, held in West Chester on Tuesday, October 28, 1873, the following preamble and resolutions, offered by Dr. Jacob Price, were unanimously adopted:—

*Whereas*, Since our last meeting it has pleased God to remove from a life of usefulness and honour our esteemed colleague, Dr. Wilmer Worthington, and whilst we bow in all humility to the dispensation, we cannot avoid, upon this occasion, giving expression to the sorrow his death has caused in the heart of every member; therefore,

*Resolved*, That this Society has heard with deep regret of the death of Dr. Wilmer Worthington, one of its founders, and through his long life one of its most faithful and useful members.

*Resolved*, That in this event our Society has sustained a loss that cannot easily be replaced, and that the remembrance of his earnest and self-sacrificing devotion to the interests of science, of the medical profession, and of humanity, should stimulate us to increased energy in the discharge of the duties that rest upon us as physicians and citizens.

*Resolved*, That this Society sympathize deeply with the family of the deceased in their great bereavement.

*Resolved*, That a committee be appointed to prepare a biographical notice of the deceased, to be embodied in the Transactions of the Medical Society of the State of Pennsylvania.

*Resolved*, That the Secretary be directed to furnish the family of Dr. Worthington with a copy of the foregoing resolutions,

and also copies to each of the county papers, and the medical journals published in Philadelphia, for publication.

## FOREIGN INTELLIGENCE.

*A new Operation for Cleft Palate.*—On the 22d of November, Sir William Fergusson, in operating on two patients for the closure of the opening in the hard palate after the cleft in the soft palate had been closed, adopted a modification of a procedure which is intended to increase the chances of success of the operation. Sir William remarked that in the so-called Langenbeck operation—that is, where muco-periosteal flaps are taken from the roof of the mouth and drawn towards the middle line—the proceeding is often unsuccessful from the fact that, after some time, the granulations which are thrown out on the upper surfaces of the displaced flaps contract and separate the union that may have taken place between the pared edges of the flaps. It is true, he observed, that some assert that bony matter is deposited on the upper surface, and that this diminishes the size of the aperture in the osseous palate. But, in demurring to this, Sir William said he thought it was hardly possible to strip off healthy periosteum from the subjacent bone. He proposed, therefore, as a remedy, that in addition to making the ordinary incisions for the flaps, the hard palate should be split on each side of the opening with some sharp cutting instrument, and that the two pieces of bone should be pressed towards the middle line, and the pared edges of the soft tissues then be brought together. By this means the central opening would be closed, but two lateral apertures would be formed. But inasmuch as the lateral openings would be but half the size of the original central one, and as there would be more likelihood of the fractured edges of bone throwing out osseous material for its repair, it was hoped that the prospect of a successful issue would be greatly enhanced.

It remains to be seen what will be the result of this ingenous device, but on the first blush it appears that by its adoption a means is offered of surmounting one of the most obstinate difficulties of plastic surgery.—*Lancet*, Nov. 29, 1863.

*Vaccination of Erectile Tumours.*—M. Blot brought the subject of vaccinating erectile tumours before a recent meeting of the Société de Chirurgie. He observed that since he had undertaken the vaccinations performed at the Académie de Médecine, a week did not pass without the parents or medical attendants of infants bringing them to have vaccination of erectile tumours performed. To pretend to cure an erectile tumour in this way is to commit an error. Blood flows away, and the vaccine does not take, or, if it does take, a small cicatrix and nothing else is the result. Erectile spots (*taches*) may be thus cured, but for erectile tumours vaccination is insufficient, and may give rise to serious hemorrhage. M. Tillaux stated that he had cured a true erectile tumour the size of a nut by vaccination, traversing the tumour in the direction of its long axis by a fine needle, followed by a thread imbued with the virus. Another thread was then passed in a direction perpendicular to this. M. Sée had cured an erectile *tache* by surrounding it with a circle of vaccinal punctures made in the sound skin. M. Marjolin was of opinion that vaccination should always be first attempted, whatever may be the seat, extent, or depth of the erectile tumour. In a tumour of two centimetres in diameter he makes from thirty to forty vaccine punctures with an excessively fine needle, sliding the skin over the tumour before puncturing. M. Desprès related the case of his own child, who was born with an erectile tumour at the end of the little finger. At the end of six months, as it was increasing rapidly, a simple vaccinal puncture was made at its most projecting part, and this sufficed to effect a cure. M. Chassaignac agreed with M. Blot, for to vaccinate in these cases is only to lose time and expose the patient to the danger of erysipelas. When a cure is accomplished, this is not brought about by the vaccine virus, but by the consecutive inflammation. M. Blot, however, did not wish to speak so

absolutely as this, for superficial slight *taches* may be cured by vaccination. But it is not suited for voluminous, deep-seated tumours. If out of fifteen punctures only three or four take, some other means must be resorted to; and M. Blot much dreads erysipelas in new-born infants. M. Marjolin, when he stated that he applied vaccination in all cases, did not mean that it always succeeded. But the inflammation which accompanied the vaccinal evolution ought to be utilized; and when but partial success was obtained, there would be a better chance for any other procedure, or a spontaneous cure may result. M. Guéniot has frequently met with a slight vascularization of the dermis of the eyelids or lips in new-born children. A large proportion of these *taches*, however, disappear spontaneously within the first six months. M. Tarnier has also observed this vascular development disappearing spontaneously, and which is not of the nature of an erectile tumour. Many of these infants present no *tache* during the first few days after birth; then a red elevation appears, which increases, especially in breadth, the vessels being very minute. In the process of spontaneous cure a whitish tissue appears on the centre of the *tache* and gradually replaces the red tissue. These cases should be watched for some months, and if the *tache* increases, in place of disappearing, vaccination should be tried.—*Med. Times and Gaz.*, Oct. 18, 1873.

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*Intussusception.*—At a recent meeting of the Royal Med. and Chir. Soc., an exceedingly interesting paper was read by Mr. Jonathan Hutchinson, "On Abdominal Section and other modes of treating Intussusception." The paper was based upon a case of intussusception occurring in a young child on whom the author had successfully performed abdominal section, after other modes of treatment had been tried without good result. This was the first successful case reported in this country. The operation had been performed nine times; in four cases with a good result, and in five unsuccessfully. The author advocated its performance in those cases where the bowel had been down for a long time, and when all other means, as insufflation, injections, etc., had proved useless.—*Lancet*, Nov. 15. 1873.

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*Epidemic Thyroiditis.*—A French local paper reports that M. Girrier, Army Medical Inspector, has been sent by the French Minister of War to St. Etienne, to study an epidemic which has prevailed in the garrison, and to apply prompt and energetic remedies. During nearly three months, the soldiers of the 76th regiment of infantry have been attacked with an inflammation of the thyroid gland. The disease, instead of diminishing in intensity, appears to have assumed within the last few weeks a degree of development which, if not dangerous, is such as to cause anxiety. At the time of the report, there were nearly two hundred soldiers under treatment in hospital. All plans of treatment adopted by the regimental surgeons have been ineffectual. Not one of the men attacked has perfectly recovered; those who were discharged convalescent have returned. Iodide of potassium has produced no appreciable effect. The non-commissioned officers at first escaped, but lately have been attacked. The soldiers of the 96th regiment remained free for a long time; but cases have occurred among them, as well as among the cavalry. While the number of patients has daily increased among the soldiers, not a single similar case has occurred among the civil population in the neighbourhood of the barracks. The cause of this obstinate epidemic is believed to be purely local. The garrisons of Montbrison, Lyons, and other large towns in the neighbourhood, are completely free.—*Brit. Med. Journ.*, Oct. 11, 1873.

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*Inhalations of Muriate of Ammonia in Chronic Affections of the Chest.*—In a recent communication to the *Société Médicale des Hôpitaux*, Dr. Libermann described the results which he had obtained through the employment of an inhalating apparatus containing muriate of ammonia, in chronic diseases of the respiratory organs. A description of the apparatus was given, by which it appeared that it was handy,

applicable to children, and available for inhalations of a great number of volatile substances. The good results afforded by the drug were attributed to its exciting, irritating action, which produces a revulsive effect. The cases which were especially benefited by muriate of ammonia thus employed included clergyman's sore-throat, in its chronic inflammatory form, and which was rapidly amended, and sometimes speedily healed; chronic bronchitis, which, through its catarrhal element, was invariably amenable to the action of the remedy; and nervous affections of the air-passages, especially convulsive cough and the various forms of idiopathic asthma.—*Lancet*, Nov. 29, 1873.

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*Hypodermic Injections of Biniodide of Mercury in Constitutional Syphilis.*—Dr. Ragazzoni (*Giornale Ital. del Malattie Venere del. Pelle*) has happily modified the formula advocated by Gamberini by adding to the solution of biniodide of mercury a little iodide of potassium, which insured the complete dissolution of the salt. His formula is: biniodide of mercury, half a grain; iodide of potassium, sufficient quantity; distilled water, half a drachm. This liquid injected at once never produces an eschar, if it is introduced properly into the conjunctival subcutaneous tissue, and not the derm.—*Lancet*, Nov. 1, 1873.

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*Treatment of Aged Persons.*—Mr. Habershon, in a clinical lecture (*Guy's Hospital Gazette*, Nov. 8) on the case of an old man who died suddenly after exposure to cold, remarked: "The old man died simply from the shock produced by coming out into the cold and fog, which, though only an inconvenience to us, was sufficient to lead to a fatal result in one whose circulation had become enfeebled, and whose vital force had so nearly lost its power. I am reminded (Dr. Habershon says) by this case of an instance of longevity communicated to me by a gentleman the other day: his mother had died at the age of one hundred and two, who, during the winter months, 'had refused to get up, saying that she was only warm in bed.' I have no doubt that it was owing to this uniform warm temperature that she lived so long; and I mention the instance as a recommendation to you, when you have to prescribe for old people, to advise that they be kept warm. You should also look carefully after their nourishment. Old people cannot eat large meals; therefore they must take them more frequently. Many old people will wake up about three or four o'clock in the morning. It is a good plan that they should have some nourishment then; otherwise, the interval between their night and morning meals is too long for their declining strength. It is by care in such minutiæ, that we may prolong the life of the aged."—*Lond. Med. Record*, Nov. 26, 1873.

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*Removal of Pigmentary Stains after Venereal Eruptions.*—M. Langlebert wishes to make known (*Gaz. des Hôp.*, Aug. 2) a simple means of effecting the removal of the pigmentary spots which syphilitic eruptions, and especially ecthyma, leave behind. Of a deep yellow, sometimes almost black, they are very lasting, those of the legs sometimes persisting for years, to the great annoyance of the patients. The various applications hitherto employed being of little avail, M. Langlebert, having remarked that blisters which had been kept open only for a few days leave, especially in individuals of a dark complexion, white traces that are well-nigh indelible, applied in an old case of syphilitic ecthyma small blisters over the syphilitic patches, and maintained suppuration for a week by means of blistering ointment. The success was complete and has induced him to recommend the adoption of the practice.—*Med. Times and Gaz.*, Sept. 6, 1873.

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*Powdered Coal Tar for Wounds.*—M. Magnis-Lahens, of Toulouse, adds charcoal to the coal tar (33 per cent. of the latter), and thus obtains a light and porous powder, which does not irritate wounds, and which is easily washed off with cold water. This combination is a very useful mixture of two antiseptic substances. The charcoal absorbs the gases formed by fermentation, coagulates the

albumen, and prevents its decomposition; thus effectually assisting the carbolic acid contained in the coal tar. Some wounds do not bear powdered applications; for these, 100 parts of the powdered coal tar should be allowed to macerate for some hours with 400 parts of spirits, and filtrated. The spirit should be of only 18° Cartier, as a stronger would dissolve the resins. As coal tar principally acts through the carbolic acid it contains, the above-mentioned maceration may be replaced by the following solution: crystallized carbolic acid, 1 part; spirit (at 18° Cartier), 99 parts. This solution is cheap and very effectual.—*Lancet*, Dec. 6, 1873.

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*Treatment of Burns and Scalds.*—Dr. de Breyne highly recommends the following treatment in *L'Union Pharmaceutique;* Hydrate of lime (newly precipitated), forty-five grains; glycerine, five ounces; chloric ether, forty-five drops. It makes up a transparent, colourless liquid, with an agreeable odour, and an alkaline reaction, according to the dose of hydrate of lime. It calms the pain, and prevents or abates inflammation.—*Lancet*, Oct. 18, 1873.

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*Lime-water in Stings of Bees and Wasps.*—M. Dauverne states (*L'Union Méd.*, Oct. 25) as the result of numerous trials that the pain and suffering caused by these may be immediately assuaged by the application of lime-water—a remedy which may always be prepared at once by the aid of a little quicklime and a glass of water.—*Med. Times and Gaz.*, Nov. 1, 1873.

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*Fracture of the Atlas and Odontoid Process of the Axis without Immediate Death.*—Mr. McCarthy, at a recent meeting of the Pathological Society of London, exhibited a recent fracture of the odontoid and atlas. The specimen was taken from a man who had fallen down the hold of a ship, on his head. He had paralysis, priapism, loss of sensation below the third rib, but no displacement of the vertebræ was detected. Twenty-four hours after he recovered sensation in the arms, trunk, and thighs, but the motor paralysis remained, but in sixty hours the man died. On *post-mortem* examination it was found that the atlas was broken in four pieces, and that the odontoid was broken at its base, but kept in position by the ligament. The cord was carefully examined, but there was no evidence of pressure, laceration, or blood-clot. The origin of the phrenic nerve was not implicated.

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*Death from Chloroform.*—A case of this occurred at Hamilton, in the practice of Dr. Dickinson, to a man to whom the anæsthetic had been administered, in order to facilitate the reduction of an old-standing dislocation of the shoulder-joint. The deceased had been a hard drinker. Dr. Dickinson used the venous injection of ammonia without any results. It is reported in the *Australian Medical Journal*, August, 1873.—*Brit. Med. Journ.*, Nov. 15, 1873.

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*Excessive Smoking.*—An inquest was held on Tuesday last on the body of a Government clerk who, according to the medical evidence, must have died from syncope induced by excessive smoking while the stomach was empty. We have never underrated the danger to which immoderate smokers are liable. When taken in excess the ordinary and pleasant effects of the herb, due probably to the carbonic acid and ammonia inhaled, are succeeded by the severer action induced by the presence of a large quantity of nicotine and empyreumatic oil in the blood, thinning this important fluid, and causing a weak action of the heart. Fortunately, these poisons find a ready exit from the system. But it is when imbibed during a period of fasting that their directly injurious effects on the cardiac organ are to be apprehended. A post-mortem examination of a person who died from excessive smoking would not probably reveal much beyond an extremely flaccid heart and slightly congested brain.—*Lancet*, Oct. 11, 1873.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on a Case of Ascites from Obstruction in the Portal Vein.* Delivered in University College Hospital. By SIR W. JENNER, Bart., M.D., F.C.B., F.R.S., Phys. in Ordinary to the Queen and the Prince of Wales.

To-day, gentlemen, I propose to speak of the case of Robert A., a man who was in the hospital recently, and whose abdomen burst. You may remember that it gave way at the umbilicus with a loud report, and a quantity of fluid came out. He had ascites, and also a considerable amount of gas in his peritoneum. You know quite well, when an abdomen is resonant on percussion, and you find the resonance—*i. e.*, the air within the abdomen—move as you move the patient, that, as a rule, the gas is not in the peritoneum, but in the intestines. In this case, however, the gas was in the peritoneal cavity itself. That is why there was a report when the abdominal wall gave way. The man had had an artificial opening made in his belly—as I shall tell you afterwards—for the purpose of letting out the fluid. It had healed but imperfectly, and, when the gas rapidly accumulated, the weak spot ruptured.

The real causes of the man's troubles were an impediment to the flow of blood through the portal vein, and an impediment to the escape of bile from the hepatic duct. To these two lesions all the others which I shall describe to you were secondary.

Whatever permanently impedes the flow of blood through the portal vein must have, as its necessary result, one or more

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of the mechanical consequences of congestion of the part the blood from which is poured into the portal vein. The blood cannot easily escape from the portal vein; and, of course, all the tributaries of the portal vein are swollen. The consequence is, that when there is impediment to the passage of blood through the portal vein, there is enlargement of the organs, the blood from which passes into the portal vein—as the spleen and the pancreas. The same impediment to the onward flow of the blood may also cause rupture of vessels. The over-distended capillaries burst, and extravasations of blood and hemorrhages occur. Common seats of hemorrhage from this cause are the stomach and the rectum—bleeding piles, hæmatemesis. This man, whose trouble I told you was the impediment to the flow of blood through the portal vein, had repeated attacks of hæmatemesis. Then patients suffering from obstruction to the flow of blood through the portal vein have effusions of serosity from the congested vessels. There is effusion of serum into the cavity of the peritoneum—ascites. This man had ascites. Again, they have "watery fluxes," as they are termed—watery flow from the congested mucous membrane. The mucous membrane of the bowels often suffers from this when it is mechanically congested. The patients have watery diarrhœa. Then thickening of all the congested textures takes place. The coats of the stomach become thickened; the peritoneum becomes thickened; the coats of the intestines become thickened. Again, inflammation, acute or chronic, is very apt to supervene in the congested part. It does not occur constantly, but frequently; so that when there is impediment to the flow of blood through the portal vein it is common to have catarrhal inflammation of the stomach, catarrhal inflammation of the bowels, peritonitis. These are common consequences. Again, ulceration of the congested surface may take place, ulceration of the mucous membrane of the bowels, of the stomach, of the rectum, of all the congested parts. This man had ulceration of the bowel and of the adhesions that had formed in his peritoneum. Then induration of all the textures occurs. Adhesions form between parts that should be free, especially in the peritoneum. Adhesion takes place between the coils of intestine, between the omentum and the intestines, between the intestines, perhaps, and the parietal peritoneum (as we saw in a case the other day), between the liver and the diaphragm, the spleen and the diaphragm, the stomach and the adjacent parts.

As the rule, when there is a *sudden* impediment to the flow through the portal vein, hemorrhage occurs. When the impediment is more slowly developed, serous effusions occur. When hæmatemesis takes place, it generally relieves greatly and at once the congested organs. You find a man's spleen big to-day; he has hæmatemesis, and to-morrow his spleen is greatly diminished in size; its over-distended vessels are emptied, its thickened tissues only remain. You know the close vascular relations between the spleen and the vasa brevia of the stomach.

When I said that some one or more of these results necessarily follow the occurrence of obstruction, I said what was not quite true. I said it intentionally, however; because I wish to fix it in your minds. It is not really *necessary;* but it occurs in the vast majority of cases, in such a large majority that I would fix it in your minds as *the* consequence. It is not the necessary consequence, because a collateral circulation sufficient to relieve the congested vessels may be established. You will remember that there are anastomoses between the inferior mesenteric veins and the hypogastric veins through the inferior hemorrhoidal, and so the blood may come back by the hypogastric vein. Again, the twigs of the portal vein and the veins of the serous covering of the liver open into the diaphragmatic and œsophageal veins, and these little communications may become considerably dilated. Again, adhesions may form between the liver and the diaphragm; new vessels be developed in those adhesions, and these new vessels may be sufficient to considerably relieve the congested portal vein. They open into the diaphragmatic and œsophageal veins. Again, the remains of the umbilical vein

which runs in the ligamentum teres sometimes remain patent. When the portal vein is stopped the remains of the umbilical vein become dilated, and this little channel grows into a big vein, communicates with the mammary veins, and so returns the blood on the surface, and you see the greatly dilated veins there carrying up the blood. You will remember, therefore, when you meet with a case in which you believe that there is disease of the liver causing mechanical impediment to the flow through the portal vein, but in which you do not get the ordinary consequences, what I have spoken of as the necessary consequences, those which you would get in the vast majority of cases—remember, I say, that you may be right in your diagnosis, although you have not the ascites, the diarrhœa, the hæmorrhoids, or the big spleen, because some of the veins of which I have spoken may be performing the extra duty of carrying off the blood from the parts which would otherwise be greatly congested.

Whatever impedes the flow of bile through the hepatic duct or through the ductus communis choledochus must impede the escape of bile from the liver; and whatever prevents the escape of bile from the liver will have jaundice following it, and all the consequences of jaundice.

We find that persons who are the subjects of the impediment to the circulation I have described not only suffer from the mechanical consequences of the impediment, such as the ascites and the hæmatemesis, which are common, and the ulceration of the bowels, which is rare, but they also suffer from defective general nutrition. This man was greatly emaciated. What is the cause of this general malnutrition? First, there is the damage mechanically inflicted on the mucous membrane of the stomach and bowels, and the consequent interference with the digestive process. There is diminished absorption from that cause. Then the mechanically over-distended radicles of the portal vein will be very unlikely to take up anything further. Again, there is the damage to the spleen and pancreas from their long-continued congestion, and the consequent interference with their functions. Again, there is damage to all the organs of the body from the damaged state of the blood consequent on these lesions and on the retained bile. These causes seem amply sufficient to account for the emaciation of the patient. Further, as I told you before, when the abdomen is greatly distended there is sufficient pressure upon the vena cava to interfere with the return of blood from the kidney; there is congestion of the kidney, and then, if the patient survives long enough, a form of Bright's disease and all its consequences.

Impediment to the passage of blood through the portal vein, and of bile through its ducts, is common enough—amongst the commonest diseases; because disease of the liver which has these results is common. But impediment to the flow of blood through the portal vein, and to the escape of bile from the hepatic duct from some condition external to the liver, is rare. It does occur, however. For example, malignant growths or hydatid cysts may press upon the portal vein and the ductus communis choledochus outside the liver. Dr. Stokes has detailed a case of aneurism of the hepatic artery, where it runs, together with the portal vein, in the border of the hepatico-duodenal fold, just above the opening of the foramen of Winslow, and which interfered with the flow of blood through the portal vein.

In the case I am about to narrate to you the impediment was the result of inflammation, induration, and contraction of the cellular tissue of the ligamentum hepatico-duodenale and the cellular tissue in the hilus of the liver—*i. e.*, of the cellular tissue in which the portal vein, and the hepatic, cystic, and common bile-ducts lie. It was the trunk of the portal vein and the trunks of the bile-ducts which were injured and narrowed.

The patient was a man forty years of age, admitted into the hospital on the 9th of February, 1869. As the patient was confused in mind, and could only be made to answer questions with difficulty, the following history was obtained from his sister.

"At about the age of eighteen he enlisted as a soldier and went to India. He remained in India for twelve years, and

returned to England about ten years since. While in India he was frequently in the hospital, as his sister had been told, on account of disease of the liver and spleen. He was a man of intemperate habits, indulging from time to time in 'drinking bouts.'" This is the common cause of cirrhosis of the liver. It is not the only cause, but it is *the* cause, the special cause, to which exceptions are infinitely rare. You will find it mentioned in books, that when making a diagnosis of a case of impediment to the flow through the portal vein, when considering whether it be from cirrhosis, which has that as its great symptom, or whether it be due to some impediment external to the liver, if the patient be a drunkard it is probable that the case is one of cirrhosis. This man was a drunkard, and there was impediment to the flow of blood through the portal vein, but he was not suffering from cirrhosis.

"About six years before admission into the hospital, after one of these debauches of drinking, he vomited a large quantity of blood." So that at that time he had probably—pretty certainly, indeed—impediment to the flow of blood through his portal vein, mechanically induced congestion of his stomach, and as a consequence rupture of the capillaries and hæmatemesis. "The hæmatemesis was repeated on four separate occasions, the last being about twelve months before his admission." No doubt he was relieved by the hæmatemesis. The congestion of the radicles of his portal vein would be relieved by the escape of blood. The loss of blood was not enough to kill him, but merely enough to relieve considerably the congestion of his spleen and of all the radicles of the portal vein.

"After the last attack of hæmatemesis, twelve months ago, the swelling of the abdomen, which had been transient before, became permanent." The transient swellings of his abdomen were probably due to flatulence. The patient had congestion of his stomach and of his bowels, thickening of all the abdominal tissues, interference with digestion, and accumulations of flatus. After the last attack of hæmatemesis the mechanically over-distended vessels relieved themselves by letting out serosity into the cavity of the peritoneum, and permanent swelling, dropsy, ascites was produced. This increased so much that "six months before his admission he was tapped just below the umbilicus, and five and a half gallons of fluid removed" The opening into the abdomen was made a great deal too near the umbilicus. A little ulceration resulted on the inner side of the opening, and obliteration of the umbilical depression ensued. It was a spot where the abdominal walls were weak, and so, when the fluid reaccumulated, the abdominal wall was distended at this spot; a very thin layer of skin covered the fluid beneath, and the skin itself ultimately gave way. He was tapped where he ought not to have been; he should have been tapped lower down, some inches below the umbilicus, a little nearer to the umbilicus than to the symphysis pubis.

"The fluid soon reaccumulated," as it was likely to do. There was a mechanical impediment to the flow of blood through the portal vein; the effusion of serum was the mechanical result; and removing the fluid did not remove the impediment. "Five weeks after the tapping he was nearly as large as he was before the operation; subsequently the distension diminished a little. Five weeks before he came under observation he had a 'fit of drinking' (as his sister called it), which lasted two days. Three days before admission he was seized, 'after tea,' with severe pain in the lower part of the right side of the abdomen. The pain was less after taking some pills; but, as he continued very ill, he was brought to the hospital."

The severe pain in the lower part of his abdomen was, no doubt, the result of perforation of his intestines, which we shall see he had. You will remember that perforation of the intestine is usually announced by sudden severe pain—not always, for now and then pain is absent. All persons of much experience have met with cases where, curiously enough, perforation occurs, I do not know why, without any pain at all. The patient is not aware of having suffered any lesion. The rule, however, is that there is intense sudden pain, with symptoms of collapse,

followed by those of peritonitis. The pills given were probably some opiates to relieve the pain.

On the man's admission into the hospital we noted that he was very thin, that his general nutrition was seriously interfered with. His skin was a dirty, slightly greenish yellow colour. The greenish tint is the tint of long-continued mechanical impediment to the escape of bile from the liver. Hence it is a common tint of cancer of the liver. A person has a gall-stone, and a sudden attack of jaundice; the colour is a deep yellow, with no greenish tint in it. But if he has a chronic jaundice, long-continued, his skin has the greenish colour. The veins on the man's hands etc. were small; evidently there was no impediment to the return of blood from the systemic venous system. They were pinkish, from anæmia. The pinkish colour of the vein is evidence of a deficiency in the red corpuscles, probably the result in this man of the interference with the nutrition in general, and perhaps also of the interference with the function of the spleen in particular.

"His abdomen was considerably distended with fluid. The umbilicus also was much distended. No scar could be seen between the umbilicus and the pubes." The fact was that the perforation had been made at the umbilicus. "During the night, at the lower part of the distended umbilicus, the skin gave way with a loud noise." It would not have been a report had there been no air there. "A large quantity, supposed to be about five pints, of stinking fluid escaped. A drainage tube was introduced, and a weak solution of carbolic acid injected. The next day (Feb. 10th) fluid continued to escape from the opening. It was very offensive, and gas escaped with the fluid." We had a full explanation of this afterwards, for we found an opening in his bowel; but remember that all collections of fluid in the vicinity of the bowel are apt to become a little offensive. "The abdomen was very tender. Pulse 108, very weak. Urine dark-coloured, containing one-eighth albumen. The man gradually sank, and died on the 11th at 6 P. M."

There was nothing to be done for him; his mind was gone: his pulse excessively feeble; there was evidence of some injury to his bowel, of a long-continued impediment to the flow of blood through the portal vein, and of bile through the bile-ducts.

After death the cavity of the abdomen contained about two pints of an opaque fluid. The external opening of the umbilicus communicated with the cavity of the abdomen. The liver, stomach, omentum, and intestines were matted together and covered with a thick layer of lymph, so hard and vascular that it must have been of long standing. There were no adhesions between the parietal peritoneum and the intestines and omentum, probably because the man had effusion of serum sufficient to separate the parietal peritoneum from the other parts before adhesions formed. The parietal peritoneum was greatly thickened and reddened, and was evidently the seat of long-continued inflammatory action. The peritoneal coat of the stomach was covered with lymph and thickened, and was the seat of numerous ulcers. The lymph had organized, had become part of the anterior wall of the stomach, and then the seat of ulceration. The posterior part of the bladder was adherent to the sigmoid flexure and the rectum, so that there was no cul-de-sac between the bladder and the rectum. The liver was inseparably united to the diaphragm; its lower edge was above the margin of the thorax.

On separating the adhesions between two of the coils of the small intestine, situated in the right iliac fossa (where the man had felt severe pain during life), an opening was exposed, about the size of a sixpence, out of which fecal matter escaped. In the interior of the bowel, a large ulcer was found at the spot. The mucous membrane around was intensely red, and coated with dirty-yellowish lymph. The situation of the ulcer was in the ileum, about a yard and a half from the cæcum. The peritoneum over the ulcer was destroyed to an extent greater than that of the opening itself, so that the muscular fibres were laid bare as well from the peritoneal as from the mucous coat. As we looked at it *in situ* we thought that the

opening might have been made from the peritoneum into the bowel. This is rare, but we thought it possible. On opening the bowel, however, it was clearly not so, for here the mucous membrane was considerably destroyed; it was destroyed over an area larger than the opening, and larger even than the destruction of the peritoneum. Thus there had been ulceration of the outer side and ulceration of the inner side, but from the congestion of the mucous membrane around, we knew that the perforation had occurred, as it usually does, from within outwards. Several small ulcers were subsequently found in the intestine which had not perforated, but only destroyed the mucous membrane. Thus it was clear that the ulceration had begun in the bowel. It was the result of the mechanical congestion of the bowel. I told you that inflammation of the mucous membrane of the bowel resulted from the mechanical congestion, but that it was catarrhal inflammation. As a consequence of this, deeper-seated inflammation with ulceration may occur, and here we had it so deep that it had perforated the bowel. The mucous membrane around the ulcers was of a deep mahogany colour.

The capsule of the liver was thickened, and the liver itself was too granular, but not contracted; the edge was thick and the tissue broke down easily under pressure. Evidently, although it was not a healthy liver, there was no such disease of the liver-substance as to seriously impede the flow of blood through it. It was not an ordinary cirrhosed liver. The gall-bladder was covered with old lymph, and its coats were thickened; it contained four gall-stones, and scarcely any bile. The cystic duct was completely closed, and the hepatic duct and the branches of the portal vein and the common duct, all the parts in the hilus of the liver, were bound together by old adhesions and a large increase of the connective tissue. This was plainly the centre of the trouble. Here the lymph was the toughest and it was evidently the oldest. Here it was the most perfectly organized, but still greatly contracted, compressing the portal vein, compressing the cystic duct, compressing the ductus communis choledochus. All the branches of the portal vein had their coats greatly thickened, and in one branch —that to the right lobe—was an old clot firmly adherent.

There were four gall-stones in the gall-bladder, but we had good reason to believe that they were not all the gall-stones that had been there. I say, "not all," because their sides were flattened, and they were small gall-stones, and they did not seem to form the whole mass indicated by the peculiar flattening. We thought it probable, from the history of the man, from his having been several times in hospital with something wrong with his liver, that he had had gall-stones before, gall-stones passing down his cystic duct, or his ductus communis choledochus, which had led to inflammation, perhaps to ulceration, and to injury of the parts around. We know that such inflammation and ulceration do sometimes result from the passage of a gall-stone, and that now and then a gall-stone is thrown out by the ulceration into the parts around. We had no evidence here that ulceration had proceeded so far, but we had evidence of inflammation which had become chronic, and had ended in exudation of lymph, the man's habits and the climate he had lived in also perhaps assisting. Lymph thus exuded contracts, and an impediment is established to the flow of blood through the portal vein. Thus, I think that the origin of the patient's trouble, the origin of the inflammation in this particular situation, where it had such a damaging effect upon his health, was the passage of a gall-stone. The liver itself was really scarcely diseased. It contained a good deal of bile from the damming back of bile into it, but the ducts were scarcely, if at all, dilated, and the cellular tissue between the lobules was a little increased. The obstruction to the flow of portal blood to the liver had, no doubt, diminished the formation of bile, and hence the absence of dilatation of the ducts in the liver. The weight of the liver was 8 lb. 7 oz.

The spleen was large and tough, the capsule thickened and adherent; it weighed 1 lb. 10 oz. This was no doubt the result of the mechanically produced congestion.

The mesentery was greatly thickened, coated with lymph such as covered the omentum; this lymph was due probably to the same cause which had led to the thickening of the intestines, to the enlargement of the spleen,—*i. e.*, the mechanical congestion, and the inflammation secondary thereto. The kidneys were enlarged; the right weighed 6 oz., the left 7 oz. The cortical substance was broad and a little speckled with red. Probably the mechanical congestion of the kidneys, assisted by the habits of the man, had given rise to inflammation, and in his cachectic condition to that low form of inflammatory action which is followed by the exudation of a great quantity of protein granules which quickly experience fatty degeneration.

We thus see, pretty clearly, considering how little history of the man we had, the course of his disease from its commencement to his death, and how the one disease, the one condition, followed mechanically upon the other; how the enlargement of his spleen, the vomiting of blood, the effusion into his peritoneum, the ulceration of his intestine, the perforation of his intestine, the distention of his belly, and the bursting of his umbilicus—how all these were the mechanical results of the primary disease, the inflammation of the cellular tissue about the portal vein and the hepatic, cystic, and common bile ducts. The further result of this was changed nutrition, for he was very thin, and evidently his nutrition was interfered with by the damage to the abdominal tissues and organs, consequent on their mechanical congestion, and on the damming back of bile in the blood itself.—*Lancet*, Jan. 3, 1874.

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### HOSPITAL NOTES AND GLEANINGS.

*Tuberculous and Strumous Diatheses.*—Dr. Wilks, in commenting on a case of well-marked tuberculosis in Guy's Hospital, made some important remarks on the subject of the tubercular and strumous diatheses. It will be seen that he completely avoided all reference to the vexed question of the nature and varieties of phthisis, but confined himself solely to the consideration of the prevention and the treatment of the disease. He said that two different outward conditions have been included under the term "strumous," so that a person unacquainted with the fact would naturally be at a loss to understand how the small, ill-developed child, with pot-belly, crooked legs, inflamed eyes, enlarged lymphatic glands, and decayed teeth, should ever be developed into a tall, well-formed, and finely-featured young man or woman, who dies of pulmonary consumption. If, however, it be fully realized that the two classes of persons belong to different diatheses, the difficulty at once vanishes. The fact is that tubercular patients, the persons who most frequently die of phthisis, are well made, have a good skeleton framework, straight limbs, a good chest (a little flattened perhaps), good teeth, and an active, intelligent mind. These patients, moreover, as a rule, dislike fermented and alcoholic beverages and fats, but are fond of active bodily exercise. But these proclivities, if greatly indulged in, tend to accelerate the onset of pulmonary consumption; for, be it observed, tubercular disease of the lungs shows itself at that period of life when the respiratory apparatus comes into more active employment. This statement may seem somewhat theoretical, but it will be found a matter of great importance in actual practice. Unfortunately many erroneous views of the nature of tuberculosis are entertained by some members of the medical profession, but more especially by the extra-professional practitioners of the healing art. These erroneous opinions are that tubercular subjects are underbred, small, and have ill-formed chests, which require to be developed by active exercise and the respiration of over-oxygenated air. From these Dr. Wilks entirely dissents, and asserts that the tubercular patient has not ill-developed lungs, which need extra physical exertion to bring them into a normal state, but agrees with the late Dr. Barlow, who held the opinion that tubercle was developed in an organ according to its functional and vascular activity. This opinion is confirmed by the observations of Rokitansky, who has found that

cyanotic patients—that is, those persons in whom there is an habitual preponderance of venous blood—are remarkably free from tubercular disease of the lungs, and that persons who have disease of the heart, or any malformation of the chest which entails a deficient arterialization of the blood, possess a similar immunity from this affection. He even says: "Nay, it is an important fact that with the establishment of a deformity of the spine in the shape of a gibbosity, even when owing to tuberculous caries of the vertebræ, the tubercular crasis is forever rooted out, in consequence of the narrowing of the thoracic spaces." Notwithstanding this, and the well-known fact that many persons who have indulged in great physical exercise, as boating-men and athletes, frequently die of acute phthisis, many writers advise physical exertion for tubercular patients. Quite recently a physician has advanced the hypothesis that tubercle is unconsumed carbon, and recommends physical exercise for its oxygenation and consequent removal. On the other hand, other observers have endeavoured to show that consumptive diseases are aggravated by an excess of oxygen. Whatever may be the value of these theoretical speculations, it will be found, as a matter of fact, that persons suffering from tuberculous disease of the lungs are benefited by rest and injured by severe exercise. Rest, combined with a nutritious diet, will be found to be the best for consumptive patients. It is not necessary to put the patient's chest in a tight jacket, nor to prevent all movement by strappings and plasters, for ordinary repose is sufficient. The beneficial influence of rest to a diseased lung may often be observed in cases where an abscess of the pulmonary tissue has perforated the visceral pleura and evacuated itself into the pleural cavity, giving rise to collapse of the lung and consequent repose. Rest, is, indeed, of more importance than climate, and the determination of this fact is more pressing than the discussion of all the theoretical questions of the intimate pathology of the disease.—*Lancet*, Dec. 6, 1873.

*Case of Impacted Fracture of the Anatomical Neck of the Humerus.*—The subject of this rare accident was a girl fourteen years of age who was admitted into the Westminster Hospital, under the care of Mr. Cowell, with the history of a blow on the shoulder, produced by a fall from a cart. The appearance presented was, in a minor degree, that of dislocation. There was flattening of the deltoid, prominence of the acromion, some loss of mobility, and a good deal of pain. These were accompanied by some swelling around the joint. The house-surgeon, by whom the patient was seen at her first application at the hospital, thought that he once detected some crepitation. The case was treated by a bandage and rest, but, the diagnosis being obscure, the patient was directed to attend on the day of Mr. Cowell's next visit.

The appearance then presented was the same as recorded above, except that the swelling of the joint was said to have increased. No crepitation was perceptible, and Mr. Cowell called attention to the advisability of always avoiding any disturbance of the parts, since, while crepitation was not generally essential to the diagnosis of fracture, much damage might be done by dislocating an impaction. At first sight this case might be one of partial dislocation, fracture of the glenoid cavity, separation of the epiphysis, or fracture of some portion of the upper end of the humerus, but may be best diagnosed by what is called the negative method—that is, by excluding one injury after another until the possible conditions are reduced to one. First, dislocation is possible, though not probable at the age of this patient; the house-surgeon had already come to the conclusion that none existed, and it was found that the head of the bone could be felt in the glenoid cavity, where it rotated with rotation of the arm. The latter fact showed also that there was no dislocation of the epiphysis—an accident much more likely to happen at the age of this patient—and no fracture of surgical neck of the humerus. The absence of any dislocation is further proved by measurement with a tape carried under

the axilla and vertically over the acromion process, for the measurement was found the same in both shoulders. There was no fracture of the glenoid cavity, for no displacement could be felt, and no crepitation could be perceived on pressing the humerus upwards against the acromion; besides, the external violence had not apparently been sufficient to produce such a fracture. There remains only one condition possible—for the deformity is inconsistent with no lesion at all—and that is fracture of the anatomical neck of the humerus. This is a rare accident, but doubtless exists in the present case. On careful examination with the finger in the axilla, the seat of fracture may be felt, for there had evidently been a slight displacement, but, fortunately for the patient, there was impaction, and a good recovery will probably be the result. Keeping the arm supported and at rest will be all the treatment required, and the patient will be kept in the hospital in order that her progress may be watched.—*Lancet*, Jan. 3, 1874.

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# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*Abortive Treatment of Coryza.*—Dr. J. S. Prout, of Brooklyn, states (*Med. Record*, Jan. 1, 1874) that he has often been able to arrest the disease in the course of an hour or less, by taking or giving large doses of the officinal tincture of the chloride of iron, 20 or 30 minims, as soon as possible after the cold is "caught." I generally find that in about half an hour there is a decided amelioration of the symptoms, which may be permanent, in which case I take or give no more of the tincture; or the improvement may pass off in two or three hours, in which case the dose must be repeated. This may be required three or four times.

I have had numerous attacks of frontal catarrh, which I have thus caused to abort. I have had the same good fortune with coryzas accompanied by sore throat.

In other cases, perhaps on account of greater severity, or from delay in commencing the treatment, I have not obtained permanent benefit from the use of the tincture. In my hands, therefore, it is not a specific.

A convenient form for extemporaneous prescription is, ℞. Tinct. ferri chloridi, Glycerinæ, āā ʒiv. M. S. One teaspoonful in a wineglass of cold water, through a glass tube, to be repeated according to circumstances. The glycerine in part conceals the iron taste.

There is a slight diuretic action. I have found no unpleasant effect on the bowels, and only a slight feeling of discomfort, which soon passed off, when it was taken on an entirely empty stomach.

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*Administration of Ether.*—At the Bellevue Hospital, New York, the administration of potass. bromid. gr. xxx, previous, and the same amount immediately following, or as soon as the patient can conveniently swallow, after the administration of sulphuric ether for the purpose of producing anæsthesia, is now regularly resorted to. The effect is to prevent the vomiting which so commonly follows the use of the anæsthetic.—*Med. Record*, Jan. 1, 1874.

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*Picric Acid as a Test for Albumen.*—At a late meeting of the Boston Society of Medical Science (*Boston Med. and Surg. Journ.*, October 23, 1873), Dr. Bowditch spoke of a new test for albumen, viz., picric acid, recommended in an article in the March number of Brown-Séquard's Archives, translated from the *Gazette Méd. de Paris*, 1873, p. 122. A drop of the fluid to be tested, urine for example, is allowed to fall into picric acid; it sinks through, and, if albumen is present, leaves a white streak. Dr. Bowditch has not found this so accurate a test as heat or nitric acid: *e. g.*:—

20 cc. of urine + 2 gtt. egg albumen gave slight reaction with heat.

20 cc. of urine + 2 gtt. egg albumen gave distinct reaction with $NO_5$.

20 cc. of urine + 2 gtt. egg albumen gave no reaction with picric acid.

20 cc. of urine + 4 gtt. egg albumen gave slight reaction with picric acid.

Better results were obtained with picric acid, when a dark back-ground was employed.

*National Medical Library*.—We regret to learn that Congress, in cutting down the appropriations for the ensuing year, proposes to reduce the amount given to the Museum and Library of the Surgeon-General's Office from the usual sum of 10,000 to 3000 dollars. While we know that the present condition of the national treasury requires a large reduction in the total of the annual appropriations, we are convinced that a wise economy does not demand that this particular appropriation should be reduced to a sum which would barely support the Museum, and entirely stop the progress of the Library. The single fact, apart from many others, that each year adds to the difficulty and expense of completing files of serial publications, and of procuring the older and rare books, should prompt a more liberal and judicious expenditure now with a view of rendering smaller appropriations requisite in the future.

The work, which is now being done in the Library of the Surgeon-General's Office under the direction of Surgeon Billings, of collecting, cataloguing, and indexing, is a labour of inestimable value, and the supply of funds for its continuance will receive the unanimous endorsement of the profession throughout the country.

—

*Obstetrical Society of Philadelphia*.—The following gentlemen have been elected officers of this Society for the present year:—

*President*—Albert H. Smith, M.D.

*Vice-Presidents*—John L. Ludlow, M.D., and John S. Parry, M.D.

*Secretary*—James V. Ingham, M.D.

*Treasurer*—D. Murray Cheston.

*Curator*—W. F. Jenks, M.D.

—

*The Chicago Journal of Nervous and Mental Disease*.—Prof. J. S. Jewett and Henry M. Bannister, M.D., announce their intention to commence the publication, in the city of Chicago, of a quarterly journal under the above title. The first number will be issued on or about this date, and the succeeding numbers in the months of April, July, and October respectively.

*Archives of Electrology and Neurology*.—Geo. M. Beard, A.M., M.D., of New York, proposes to found, with the above title, a journal devoted to the special departments of electricity, in its relations to medicine and diseases of the nervous system.

It is contemplated to issue the first number of the *Archives* early this year. It will be published at first semi-annually.

—

Obituary Record.—Died at Cambridge, Mass., Dec. 14, 1873, from nervous prostration resulting in paralysis, affecting the respiratory muscles, and especially the pharynx, after an illness of only a week, Louis John Rudolph Agassiz, aged sixty-seven. Agassiz originally studied medicine, and obtained a degree of M.D., but he never engaged in practice, devoting himself to the cultivation of, to him, the more enticing field of natural history, and with such success that he has been universally regarded as the most eminent of living naturalists.

—— at New York, Dec. 9, 1873, Wm. C. Roberts, M.D., Vice-President of the New York Academy of Medicine, and the author of many medical papers, which display research and erudition, published in various periodicals.

—— in Oswego, Jan. 6, 1874, William R. Bates, M.D., aged 75 years. A practitioner of medicine for fifty-three years.

—— in Burlington, Iowa, November 14, 1873, John Flournoy Henzy, M.D., in the eighty-first year of his age. Dr. H. served as surgeon's mate in the war of 1812–14, and was at the battle of the Thames. In 1830, he was elected Professor of Obstetrics in the Ohio Medical College. In 1834 he removed to Bloomington, Illinois, and in 1845 to Burlington, Iowa.

## FOREIGN INTELLIGENCE.

*Treatment of Non-Parasitic Sycosis*.—Dr. Tilbury Fox, in some practical notes on cutaneous subjects (*Lancet*, Dec. 27, 1873), makes the following remarks on this subject:—

No disease, I take it, is more unsatisfactory to treat than the common inflam-

mation of the hair follicles of the beard and whiskers, to which the term sycosis non-parasitica is applied. On the continent, especially in Germany, the practitioner is advised to adopt epilation, and to apply some simple astringent ointment; and there is a great disposition nowadays to regard epilation as the remedy for the disease under notice. The reason for epilating is variously stated. Some affirm that the inflammation in sycosis is caused by a premature development of a new hair in the follicle, and that it is necessary to its cure to rid the follicle of the old hair. Others think that suppuration extends to the root of the hair, and that epilation relieves the tension of the parts and permits the exit of the pus. The first explanation will not bear examination. The second is true in part. In nonparasitic sycosis inflammation travels downwards, and may reach the bottom of the follicle, the root of the hair being bathed in pus, whilst the hair is loosened from its surrounding connections, and lies, as it were, a dead piece of tissue in the follicle. In such cases epilation does but get rid of the loosened hair, and its extraction allows the escape of pus that would otherwise be pent up. But in many cases the inflammation does not proceed to the extent of causing suppuration in the deep part of the follicle, the hairs are not loosened in the follicles, and their extraction gives great pain, and can do no good. Epilation is, therefore, a fit procedure only at a certain stage of sycosis—if the skin is much inflamed, the follicles freely suppurating, and the hairs are thereby loosening or loosened in them.

The treatment which I have found most successful may be summed up as follows: In the early stage, when the follicles are very hyperæmic, saline aperients in persons of full habit; or aperient tonics, such as sulphate of magnesia with sulphate of iron, in those who are debilitated; together with hot fomentations, and simple, soothing applications which exclude the air, locally. When there is free suppuration, the same internal remedies, together with the removal, by epilation, of the loosened hairs from freely suppurating follicles, and the application of mild astringents, such as zinc lotions and ointment; and, lastly, in the subacute or chronic stage, where there is only a suppurating follicle here and there, but mostly a number of indurated tubercles—*i. e.*, follicles thickened by hyperplastic growth of the connective tissue—a course of Donovan's solution, together with, locally, hot fomentation and the application of a weak nitrate of mercury ointment (a drachm and a half to an ounce) night and morning. Of course, for persons of scrofulous constitutions, cod-liver oil and iron are to be given in combination with alterative remedies. I fully admit that the exhibition of Donovan's solution is in great part an empirical proceeding; but I prefer it to any other remedy, and have reason to speak with confidence as to its efficacy in sycosis when employed in the way and at the particular stage above indicated. Lastly, I may add that it is an easy matter to do harm in sycosis by the injudicious use of local irritants, which intensify the hyperæmia and the hyperplastic thickening; and I believe this to be the radical fault in the treatment of sycosis.

—

*Belladonna Plaster for Vomiting.*—M. Gueneau de Mussy recommends for the cure of vomiting a plaster of 12 centimetres (about 4½ inches), in diameter, composed of diachylon plaster 2 parts; theriac plaster 2 parts; extract of belladonna 1 part. This plaster may remain applied for fifteen days without being renewed. By this plaster he has arrested vomiting which had resisted treatment by various means for forty years; and he has also used it successfully as a prophylactic and curative means in sea-sickness.—*La Tribune Méd.*, 14 Dec. 1873.

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*Use of Chloral Hydrate in Gonorrhœa.*—Dr. Parona has made (*Giornale Ital. della Malat. Ven.*, Oct. 1873) an extended trial of chloral as an injection, both in the gonorrhœa of men and in vaginal blenorrhagia, and speaks of its value as a sedative and also as an astringent. He first tried it in 1870. The strength of the injection is one gramme or one gramme and a half of chloral to 100 grammes of water.

A 2 per cent. solution is too irritating, and is rarely tolerated. The injection is used three times a day, and retained as long as possible. The best time to commence it is when the acute symptoms are subsiding, and it then not only relieves the pain and distress on passing water, but also removes the discharge.—*Med. Times and Gaz.*, Jan. 3, 1874.

—

*Intravenous Injection of Ammonia in Snake-bite.*—Mr. Fayrer calls attention to the following extract from the *Opusculi Scientifici de Felice Fontana*, nearly one hundred years old, which shows that history repeats itself in science as well as in other matters.

"It is very true that several cases of cure of viper bites by the injection of spirits of hartshorn (ammonia) into the veins, have been reported by the Italian papers, and it is also true that these cures appear surprising and almost miraculous from the manner in which they are presented to us; it appears moreover, that certain persons take a quiet pleasure in assuring the public that the true specific against the poison has at last been found, that which I have in vain sought for many years, whilst with philosophical candour I have declared the inutility of my long researches on the subject.—*Indian Medical Gazette*, July, 1873.

—

*Use of the Aspirators in a Case of Poisoning.*—M. Dieulafoy has published a case communicated to him by Dr. Paul, of Danville, of an infant poisoned six hours after birth by a dessertspoonful of Sydenham's laudanum. An emetic producing no effect, a sound was introduced into the stomach by the œsophagus, a spoonful of liquid withdrawn, and half a glass of tepid water injected. The symptoms growing rapidly worse, Dr. P. had then at once retested Dieulafoy's aspirator. He injected into the stomach a quantity of black coffee, and then withdrew it; which operation he repeated a dozen times in ten minutes, removing the fluid every time. Other means were also employed, as sinapisms, a purgative enema, followed by one of black coffee, electricity, etc. After thirty-six hours the infant was able to take the breast, and ultimately got quite well.—*L'Union Médicale*, Dec. 20, 1873.

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*The Abuse of the Iodides in Secondary Syphilis.*—Prof. Gamberini, the well-known syphilographer of Milan, has lately called attention to the way in which nowadays the iodides of potassium and sodium are prescribed "in all the forms of secondary syphilis," and deprecates such practice strongly. He says—"The iodides are used as if mercury were no longer of any value. I have examined a large number of cases treated in this way, and have been able to prove that ordinarily the iodides are not beneficial, and that the virtues assigned to them are only the expression of the natural pauses in the course of the syphilis. It is my firm belief that the prolonged use of the iodides as an exclusive remedy in secondary syphilis only serves, as a rule, to impoverish the blood, and so to accelerate the appearance of syphilitic chlorosis." Professor Gamberini recommends those who are sceptical of the truth of his assertions to compare for themselves cases as nearly similar as possible treated with mercury and with the iodides. Is not the warning given above as applicable to English as to Italian medical men?—*Med. Times and Gazette*, December 27, 1873.

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*Bloodless Operations.*—Dr. G. Clementi, of Naples, claims (*Lancet*, Jan. 3, 1874) for Italian Surgeons the credit of first employing the methods of Esmarch and Dittel, for bloodless operations. Dr. Silvetti, he states, published an account of the latter method in *Gaz. Med. Ital.*, in 1862, and of the former in the same Journal for 1871.

—

*Aneurism of the Arch of the Aorta.*—At a recent meeting of the Liverpool Medical Institution (*Med. Times and Gaz.*, Dec. 13, 1873), Dr. Alexander exhibited a specimen illustrating a fact which does not seem to be generally recognized, although it has been established by a series of very interesting cases by Dr. Axel Key, translated by the late Dr. D. W. Moore, of Dublin, and published a few years since in the *Medical Times and Gazette*—viz., that

aortic aneurisms, however large, and however near to the heart they may be, do not cause enlargement of that organ so long as the semilunar valves are competent. Although in the case in question the aneurism was a large one and near to the heart—occupying a portion of the ascending and transverse parts of the arch—that viscus appeared to be smaller than usual, although its tissue was healthy.

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*Pepsinomania.*—We learn, from the *Chemist and Druggist*, that Dr. SCHACHT, a councillor and recently president of the Apotheker-Verein, lately read a paper on "Pepsine and Schering's Pepsine Essence." He showed that pepsine only dissolves albumen in presence of free acid, but that a given small quantity of pepsine will effect the solution of any given larger quantity of fibrine, on the same principle as a small quantity of sulphuric acid acting upon alcohol will continue to produce ether. Further, he showed that when the limits of its dissolving capacity are attained, yet by dilution with water and further addition of acid more solution will be effected. He also maintained that a stomach had never been found without pepsine, that the natural pepsine was never entirely destroyed by the process of digestion. From this he concluded that the administration of the artificially obtained product could only be a work of supererogation. It is evident, also, from these premises, that the value of a pepsine cannot be estimated by the quantity of fibrine which it will dissolve, but by the time it occupies in dissolving it. Dr. Schacht's experiments also went to prove that wine or alcohol were the worst possible vehicles for the administration of pepsine. It was probable that the tannin of wine almost entirely hindered the catalytic action of the pepsine. Some experiments were shown to prove that it was much more effective if dissolved in water. Of course, in either case hydrochloric acid is necessary. Dr. Schacht chastised the "pepsinomania" in England, and referred to such preparations as Mr. Lorimer's sauce, which, however, was, he thought, preferable to the pepsine essences or wines. The speaker concluded that the administration of pepsine or any of its preparations was altogether unscientific, on the ground that no stomach had yet been observed in which the remedy was already absent.—*British Medical Journal*, December 27, 1873.

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*Cod-liver Oil Loaves.*—MM. CARRE and LEMOINE state that of all means of disguising the taste of cod-liver oil its introduction into bread during panification is the best. Every pound of bread should contain seventy-five grammes of oil (five spoonfuls) and about ninety grammes of milk. Small loaves may be made weighing 150 grammes, and containing only two spoonfuls of oil. They are very white and pleasant to look at, and have so little taste of the oil that both children and adults eat them with ease. Thirty-four of these rolls are delivered every day at the Enfants Malades for the use of M. Bouchut's little patients, and the children look out for them with pleasure. They are easily digested, and create no repugnance whatever. In private practice adults make use of them as their ordinary diet.—*Medical Times and Gazette*, Aug. 23, 1873, from *Bulletin de Thérap.*

—

*Death following the Inhalation of Ether.*—The following case occurred at the Royal South Hants Infirmary, and is recorded in the *British Medical Journal* for October 11, 1873.

David N., aged 14, a strumous lad, who had suffered from repeated attacks of corneitis, was admitted an in-patient of the above institution on September 25th, 1873, under the care of Dr. Lake. On Wednesday, October 1st, he was brought into the operating room in order that iridectomy might be performed. When on the table he exhibited considerable alarm, and required some persuasion before he was induced to lie down. Dr. Griffin having taken charge of the pulse, half an ounce of ether was poured on a sponge contained in a cone of spongiopiline, and the latter was closely applied to the mouth and nose. After a few minutes' inhalation, the ether being nearly exhausted, three drachms more were

poured on the sponge. Shortly after commencing to inhale this second quantity he began to struggle violently, getting at length into a state bordering on opisthotonos, his face becoming intensely scarlet. Dr. Griffin then announced that his pulse, which up to this time had been perfectly natural, had become very feeble. The ether was at once discontinued, when, the pulse having improved, Dr. Lake operated, no more ether being administered. At the close of the operation, which occupied only a few seconds in its performance, and before the eye could be bandaged, the pulse became imperceptible, the breathing was suspended, and the countenance livid. The tongue was drawn well out of the mouth and held there; the calves of the legs were vigourously flagellated, and the chest freely slapped with a wet towel. The effect of these measures was to cause the patient to respire freely, to cry out lustily, and to kick about on the table; but this improvement did not last long—probably about a minute. The pulse at the wrist did not return, and the breathing again stopped. Artificial respiration—at first by Silvester's method, afterwards by Marshall Hall's—was then had recourse to; at the same time an intermitted current of faradic electricity was passed in the course of the phrenic nerve; this at first caused strong periodic contractions of the respiratory muscles; but after about ten minutes or a quarter of an hour these ceased to respond to the current, and it became evident that life was extinct. These measures were, however, still persevered with for about three-quarters of an hour. At the necropsy, twenty-one hours afterwards, the brain was found to be healthy, and not much congested. The right cavities of the heart were full of dark fluid blood, but the left cavities contained only about a drachm of a similar fluid. The valves were healthy. The muscular structure, although somewhat flabby, presented no decided evidence of fatty degeneration. The lungs were congested, and of a somewhat bright red colour. The other organs were healthy.

Dr. Henry J. Bigelow, of Boston, thus interprets (*Boston Med. and Surg. Journ.*, Nov. 20, 1873) this case:—

"A feeble boy was etherized. During this process, though only partially narcotized, he was very completely asphyxiated, and, when nearly dead, was operated on without efforts at resuscitation. When at last his absolute prostration awakened serious alarm, he was vigourously flogged with the view of restoring his exhausted strength; and under this active stimulus was excited to a final muscular effort which expended and extinguished his flickering vitality. I believe that such a death might have occurred without the ether."

Dr. Bigelow unhesitatingly submits asphyxia as the primary cause of death, and offers the following explanation:—When we say "death from chloroform," we mean death by a shock or poison peculiar to chloroform, even when inhaled by a healthy person, under the most favourable circumstances, with abundance of air, and with every precaution; sometimes occurring at the beginning of anæsthesia undertaken for a trivial operation, almost as if by prussic acid; the sudden failure of a normal pulse indicating that the patient is beyond recovery.

"With ether, I believe this to be simply impossible. It always acts slowly, never depressing the vital powers suddenly, or beyond recovery, without fair warning by the pulse in time to avert danger by the simple expedient of filling the lungs with unadulterated air."

—

*The Fog.*—The recent fog in London will long be remembered as one of the most disastrous this generation has known. To persons with cardiac and respiratory disease it has in numerous instances proved fatal. The accidents were, moreover, sufficiently numerous, and in several instances in the East of London deaths by drowning in the canal and river occurred. From inquiries we have made at the principal hospitals we learn that at the Charing Cross hospital there were thirty or forty cases of accidents, and that the patients in the hospital suffered severely, especially those affected with heart and lung disease. The death-rate during the days the fog lasted was unprecedented—in fact, higher than since the hospital has been established.

In one day six post-mortem examinations were made. At St. Thomas's a man was brought in dead from having fallen from his cab. He had a scalp wound and bruises on the scalp; and a boy was brought into the hospital burnt in the face with a torch. At King's College Hospital there were two cases of accident—one a crushed hand, another a crushed toe. At Guy's there were four. A man at work upon the leads of a city warehouse in the fog walked off the building, and fell headlong to the ground. He fractured his skull, and was taken to Guy's, where he died shortly after admission. A fog signal-man was run over. At St. Bartholomew's there were no accidents but an increase of in-patients. From the Royal Free we have reported the accelerated death of in-patients. At the Middlesex a case of fractured fibula was received, and a patient suffering from concussion and scalp wound from falling off a mail-cart. At St. Mary's the in-patients are reported to have suffered severely. At St. George's there was a case of burn from a torch, and a case of bruise from falling over the park railings. The in-patients at St. George's and also at the Westminster Hospital are reported to have suffered severely.—*Med. Times and Gaz.*, Dec. 20, 1873.

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*Memorial of the late Sir James Y. Simpson.*—At a meeting of the Committee of Subscribers, for a memorial of the late Sir J. Y. Simpson, held in December last, it was unanimously resolved to commission Mr. William Brodie, R. S. A., to execute a statue in bronze, to be erected in some suitable site in Edinburgh.

—

*Cancer of the Liver.*—At a late meeting of the Liverpool Medical Institution, Dr. Glynn exhibited a large cancerous tumour of the liver. The tumour, although undoubtedly malignant, was single, occupying almost the whole of the left lobe, which was greatly enlarged; the increase in size was entirely upwards and posteriorly, the edge of the liver never having descended below the margin of the thorax; a large thrombus had been formed in, and completely blocked up, the portal vein, causing extensive ascites during life; and almost up to the period of death there had been an absence of any very severe symptoms. With reference to the last point, the president (Dr. Cameron) remarked on the frequency with which, in extensive cancerous disease of the liver, there was a similar absence of symptoms; and Dr. Carter mentioned that at the first meeting of the Society, in the previous year, he had exhibited a liver universally infiltrated with cancerous nodules, and weighing nearly eleven pounds, which he had removed from the body of a patient who had died after a few days' illness in the Royal Northern Hospital, and who, almost up to the time of his admission, had been working as a labourer on the hospital building—as he himself said, without any inconvenience or consciousness of ill health.—*Med. Times and Gaz.*, Dec. 13, 1873.

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*Journal de Thérapeutique.*—A new French journal with the above title is announced to appear on the 1st of January under the editorial management of Dr. Gubler, assisted by Drs. Bordier and Labbé.

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*Bulletin de Thérapeutique.*—This very successful journal has been sold by the executors of its late proprietor, Dr. Bricheteau, for 115,000 francs, to Dr. Dujardin-Beaumetz, who has added to the editorial staff three members of the faculty, viz., Profs. Béhier, Bouchardat, and Dolbeau.

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Obituary Record.—Died, in London, on 24th December, aged forty-seven years, of heart disease, Francis C. Webb, M.D. Edin., for some time past sub-editor of the *Medical Times and Gazette*, and since the temporary withdrawal of Dr. Druitt, on account of ill-health, editor in charge.

—— in London, Dec. 18, 1873, from a chronic abscess in the posterior mediastinum, and secondary pyæmic abscesses in brain, Henry W. Fuller, M.D., Senior Physician to St. George's Hospital, and the author of a valuable treatise on Rheumatism and Gout, and on Diseases of the Heart and Lungs.

## *NOW READY.*

### BARNES ON WOMEN.

## A CLINICAL HISTORY OF THE MEDICAL AND SURGICAL DISEASES OF WOMEN.

By Robert Barnes, M.D., Examiner in Obstetrics and the Diseases of Women at the University of London and the Royal College of Surgeons; Obstetric Physician and Lecturer on Obstetrics and the Diseases of Women to St. Thomas's Hospital, &c. With One Hundred and Sixty-nine Illustrations. In one very handsome octavo volume of about 800 pages: cloth, $5 00; leather, $6 00.

There has seldom appeared in the English language a more complete, thorough, and exhaustive treatise on any medical subject than the one now under notice. Dr. Barnes had already established for himself, by his writings and his practice, a position second to none as an obstetric authority. He has had probably the largest operative midwifery experience of any living practitioner, and his name is associated with some of the most important improvements in midwifery practice. The work which has just issued from his pen will go far to establish him as an equal authority in the special department of practice of which he treats. We can only repeat that, as a thoroughly sound, practical, clinical treatise, we know of no English work which can compare to this of Dr. Barnes. To the so-called specialist, as well as to the general practitioner, it will prove a most useful guide.—*The London Lancet*, Jan. 10, 1874.

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Unquestionably the best modern book on Midwifery in our language.—*Brit. and For. Med.-Chir. Review*, Oct. 1873.

**HENRY C. LEA—Philadelphia.**

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## CLINICS.

### CLINICAL LECTURES.

*Pyæmia in Private Practice.*—PRESCOTT HEWETT, Senior Surgeon to St. George's Hospital, relates some most interesting gleanings from private practice, "the clinical results of which," he observes, "may be made valuable, and all the more so when contrasted with those of hospital practice: and the subject to which I shall direct your attention is that of Pyæmia, a subject than which none is more important, and the consideration of which, in some of its bearings, has of late years been largely occupying the attention of our profession. The few observations which I have now to offer you on this subject will be confined to cases occurring in private practice.

"A young lady, aged 15, stoutish, but of good general health, came under my care for a congenital cystic tumour at the root of the neck. When an infant, an attempt had been made to remove this tumour, but a bit of it was left, as it was closely adherent to the large vessels. For several years after this operation nothing was noticed in relation to this tumour, but for two or three years previously to seeing my patient it had, without any apparent cause, taken to growing; and when I was consulted it occupied the whole of the lower part of the left side of the neck, and projected beyond the clavicle. At a consultation, with the late Mr. Keate, who had performed the operation, it was determined that single-thread setons should now be used, and two of these were introduced into the tumour. In a few days intense inflammation set in, and suppuration followed; a quantity of matter was let out, the

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swelling subsided, and for some days everything appeared to be going on satisfactorily; then came rigors and sweating, but without any increase in the local trouble. After awhile it became evident that the patient was suffering from pyæmia, the mischief being in the left lung, and for several days the condition was most perilous; but one afternoon, after a violent fit of coughing, a large quantity of offensive matter was suddenly brought up, after which the more dangerous symptoms gradually subsided, and the patient ultimately recovered, and remained perfectly well, without any further trouble as to the tumour. In this case the patient's room—large, lofty, and well ventilated—was in a well-found house in one of the best streets in town.

"A hale old gentleman, close upon 80, who had long enjoyed must excellent health, had a small warty growth in the skin, just over the insertion of the tendo Achillis. This growth I removed, as it constantly became chafed, and troubled him much in walking. I made him lay himself up for a few days, and then, as the trifling wound was all but healed, he was allowed to go about a little, but, being of very active habits, he one day took a longer walk than usual. This was followed by some slight inflammation of the wound, which, however, soon subsided, and he was on the eve of returning to his usual avocations when rigors and sweating made their appearance; then came an immense deep-seated abscess in the thigh, under the constant draining of which he ultimately sank.

"I was called in consultation to a gentleman who was suffering from pyæmia, and who a short time before had had a small wart removed from the scrotum. He died. Details of this case are given further on, as I had to attend this gentleman between three and four years previously for a former attack of pyæmia.

"Shortly after I had begun practice, I removed a small sebaceous tumour from the scalp of a lady. Everything went on well for the first few days; then came erysipelas of the scalp, which was subsequently followed by pyæmia and death. As far as one could judge, the conditions under which this trival operation was performed were all favourable ones. The patient, middle-aged, and not stout, had some months previously undergone, without a bad symptom, a similar operation for the removal of three other sabaceous tumours. The bedroom, in a house in one of our most open and healthiest squares, was large and well ventilated; the weather was temperate, and the patient had remained in the house after the operation.

"I operated upon a middle-aged lady, of good general health, for scirrhus of the breast, and for the first eight days everything looked promising; then came a rigor, followed by erysipelas around the wound, which for a few days went on slowly spreading; subsequently pyæmia made its appearance, and under this she gradually sank. The house in which the operation was performed was in one of the best streets in Pimlico. The bedroom was of good size, and well ventilated.

"About a month afterwards I operated upon another lady for scirrhus of the breast. Middle-aged and slim, she was of a sallow complexion, but in good general health. In this case, too, everything promised well for the first few days; then came a severe rigor and sickness; erysipelas soon made its appearance around the wound, whence it gradually spread. Matters went on thus for a few days; then there was pyæmia, and in a few days more the patient was dead. In this case, the operation was performed a few miles out of town. The bedroom, very large and well ventilated, was in a large well-built house, with all modern appliances, and situated on a heath, on elevated ground, overlooking a wide expanse of country. As far as one could judge, no better or healthier situation could have been selected for an operation.

"A lady, aged about 45, had a large sero-cystic tumour of the breast, some of the cysts of which occasionally suppurated, and were, under such circumstances, sometimes opened and sometimes allowed to burst. Matters went on thus,

as she would not hear of an operation, for between eight and nine years, the general health being as good as ever between the attacks. At this period a small cyst suppurated, and was allowed to burst, shortly after which erysipelas made its appearance round the edges of the little sore; then in a few days came rigors and sweating, with pain and great swelling of one of the knee-joints, and in a few days more this lady sank. At the time of the bursting of the cyst the patient was in her usual good health; her bedroom, fair sized and well ventilated, was in a house in a part of town generally considered to be one of the healthiest.

"A young gentleman met with an accident to his shoulder, which led to inflammation of the joint, and for this he ultimately consulted me. After awhile the inflammation subsided, leaving the joint somewhat stiff. Then, persuaded by some friends, he went to a bone-setter, who pronounced that the bone was out, and proceeded to put it back, as he said. The manipulations gave him great pain, and were followed by a recurrence of inflammation in the joint, for which he once more fell under my care. Suppuration of the joint ensued, and abscesses burst in various directions. Thus matters went on for a time, then came rigors, profuse sweatings, and a sodden appearance of the skin, with an anxious countenance, a running pulse, and great loss of flesh—the joint itself and the parts around it being meanwhile without any increase of mischief. Although tall and slim, this gentleman, up to the time of going to the bone-setter, had been in good health, and his family was healthy. He remained in this perilous condition for some time, looking as if secondary abscesses might occur at any moment. All this time he lived out of town, in a good country house, well cared for, and with plenty of fresh air. With the winter coming on, I sent him to the south of France, where, after a residence of some months, the more threatening symptoms gradually subsided, and when he returned to this country there was a decided improvement in his general health; but he was still far from well, and he remained more or less ailing for between two and three years, at the end of which period he was in fair health, with a permanently stiff joint, the abscesses about the shoulder having gradually dried up.

"A middle-aged lady, in fair health, was supposed to be suffering from a sharp attack of sciatica on the right side, and for this she was ultimately sent to Wiesbaden; but after a time, finding that there was no improvement as to the pain, she returned home, and for some months went on creeping about, under the supposition all the while that she was suffering from sciatica. It was at this period that I was consulted on account of a swelling which had been gradually making its appearance in the corresponding groin. The swelling proved to be an abscess which extended into the iliac fossa; and, on further investigation, the sacro-iliac joint was found to be the source of all the trouble. The abscess was allowed to burst, after which everything went on satisfactorily for some three weeks, when pyæmia made its appearance, and was followed by death in a week. This lady lived in a house on a hill, a few miles out of town. The house was in every respect well found, and her bedroom was airy and well ventilated.

"I was telegraphed for a few miles out of town to a gentleman about thirty years of age, who was thought to be suffering from acute inflammation of both ankle-joints, and inflammation of the left lung. The case, on closer examination, proved to be one of pyæmia, in connection with suppuration about the tonsils. In a few days, the inflammation around the ankle-joints ended in the formation of matter, which was let out; after which this patient gradually recovered, and in a few weeks was restored to his usual good health. This case has already been alluded to as that of the gentleman who died of pyæmia after a trifling operation for the removal of a small wart from the scrotum. Between the two attacks of pyæmia in this case, there was an interval of between three and four years. The first attack occurred in the country, and the second in town.

"Recently, too, I have seen another gentleman, who, in connection with suppuration about the tonsils, had symptoms of poisoned blood—rigors, profuse sweat, sodden skin—under which he sank.

"A young gentleman, aged 18, had a severe attack of typhoid fever, from which, however, he was making a good recovery, when, about a fortnight after all symptoms had disappeared, he again became feverish, and soon afterwards, without having met with any accident, he complained of pain along the shin-bone; swellings, which were very painful, formed along the surface of the bone; suppuration followed; the abscesses were opened, and went on discharging for some time, after which they gradually dried up without further mischief.

"A lady's maid, aged about 30, had a severe attack of typhoid fever in the country. She recovered, and, being considered convalescent, came up to town, shortly after which smart feverish symptoms made their appearance, and were soon followed by swelling, affecting principally the knee, and extending some distance down the front and inner side of the leg. For awhile the symptoms were very severe, and ended in extensive suppuration about the upper part of the tibia; the matter was let out, and the patient gradually recovered; but the free use of the limb was not regained for a couple of years, and during this period several bits of bone came away.

"A delicate middle-aged lady had typhoid fever, which in due course passed away, leaving her weak and ailing, with now and then a recurrence of slight feverishness. After a time, this feverishness became more marked, and then she began to complain of very severe, deep-seated pains in various parts; first, at the upper and inner side of the tibia; then, at subsequent periods, over the lower part of the shoulder-blade, along the middle part of the spine, over the ribs, as well as over the crest of the haunch-bone. The pain in each of these parts was followed by swellings, and ultimately by abscesses, some of which were large and deep-seated. The abscesses were allowed to burst, and then, after the subsidence of the swelling, a probe was, in each instance, easily passed down to the periosteum, and in some parts the bone was found bare. The drain was great; hectic set in; and, after intense suffering, with occasional but limited mischief about the lungs, this lady sank.

"A delicate-looking girl, aged 18, ran a needle into the fleshy part of the leg, where it broke off, but could be felt projecting slightly beyond the skin. It was pulled out, and she went about her work as usual; but in a few days the tiny wound festered, and in a few days more she was admitted into St. George's Hospital with symptoms of pyæmia, rigors, profuse sweatings, and swellings in various parts. Subsequently came evident signs of mischief about the lungs, and she sank within a month after the trifling injury. The needle, according to the patient's account, was quite clean; and she stated that she had never been laid up before, and had always had good health.

"A young gentleman, aged 18, and apparently in good health, whilst bathing, ran a small splinter of wood into the fleshy part of the great toe. The splinter was immediately plucked out, and he went about as usual for several days, as if nothing had happened. Then the spot became painful, and a tiny abscess formed; it was attended to, but in a few days it was followed by urgent symptoms—severe rigors and most profuse sweatings; abscesses formed in the leg—one, a very large one, was deep-seated and in the calf; as they appeared they were dealt with, but for weeks the sweatings were so profuse that it was necessary to change the bed-linen several times in the twenty-four hours. Ultimately, however, the patient recovered, and he left his bed, a mere skeleton, between four and five months after the onset of the attack. His bedroom was fair-sized, well ventilated, with a large window looking over a wide expanse of country, the house, a recently built one, being on the outskirts of a town.

"A gentleman, middle-aged, was tripped

up in the street, and fell violently upon his elbow, the lower bones of which were thereby dislocated backwards, and partially thrust through the skin. The dislocation was easily reduced, and for a few days everything went on satisfactorily. Then came suppuration of the joint, followed in about a fortnight by severe rigors and profuse sweating, with swellings in various parts, and he died a month after the injury. His bedroom was a fair-sized one, well ventilated, and in a house in a good street on the north side of, and not far from, Hyde Park.

"A little boy, aged 6, met with a slight accident to his foot, which was followed by acute periostitis of the bones of the tarsus; this ended in suppuration; some of the joints were destroyed; and, at different periods, several abscesses formed in various parts—over the great trochanter, over the crest of the ilium, and in the sacro-lumbar region, as well as over the bones of the skull in divers places. The suffering was intense, with low muttering delirium and rapid wasting, and to such an extent that the child was soon reduced to a mere skeleton. Thus matters went on for some weeks, after which the abscesses gradually dried up; ankylosis of the bones of the tarsus took place, and when last seen, about a couple of years after the attack, he was a strong, active lad. All this occurred some miles out of town, in a good house in a healthy part of the country.

"I was summoned a long way into the country to a young lady labouring under symptoms of a typhoid character, the origin of which was obscure. It appeared, however, that she had recently had measles, which had been followed by a slight discharge from the left ear. The recovery from the measles had been good, and she was going about, when rigors and sweating occurred, and were followed by fever, a dry, brown tongue, and great prostration; and such were the more obvious symptoms when I first saw this young lady. On further inquiry, it was now found that the discharge from the ear had stopped; the intellect was quite clear; there was no pain in the head, no swelling in the neighbourhood of the ear, but there was pain upon pressure immediately below the mastoid process, and this tenderness existed also some way down the side of the neck, in the course of the internal jugular vein. From this it was inferred that inflammation had spread from the ear to the lateral sinus and internal jugular vein, and that, in all probability, secondary abscesses would follow. In a few days, a large abscess showed itself in the left sterno-clavicular articulation; then came pain and swelling about the left knee and ankle, and inflammation at the back and lower part of the left lung; and ultimately there was a large deep-seated abscess at the back of the left hip. The abscesses were opened in due course, but the mischief about the knee and ankle-joint, and in the lung, subsided; the patient gradually recovered, and in a few months was quite well again. The conditions under which this young lady was placed were unexceptionable—a large, airy, well ventilated room looking on to an open country.

"A young lady had, after her confinement, severe symptoms of low peritonitis, and was in great peril for some days; she recovered, however, and appeared to be going on well for a time, when the left shoulder became very painful, and for this I was asked to see her. Examination proved that the joint itself was not affected, but the parts around were much swollen and very painful, and especially so in front of the joint. Ultimately, a large abscess formed in this situation; it was opened, and the patient got well and went into the country, where, some weeks afterwards, deep-seated matter formed in the pelvic region; this burst into the vagina, and after a time she recovered completely, and has remained in good health ever since.

"An officer in one of our light cavalry regiments, aged 18, came under my care for gonorrhœa. The symptoms were severe, and so he remained at home, and was treated with opiates and demulcents. About a fortnight after he had been under treatment, symptoms of what appeared to be gonorrhœal rheumatism

made their appearance. First, the left shoulder-joint was affected, but after awhile the symptoms subsided; then, without any apparent cause, came rigors, profuse sweatings, and a dusky appearance of the skin, with great disturbance of the general health. These symptoms were soon followed by intense pain in the left sterno-clavicular articulation, which became much swollen, and in a few days presented evident signs of fluctuation. A large quantity of matter was let out. Inflammation and suppuration in and about the right hip-joint, accompanied by most intense pain, followed. In due course the matter was let out; and subsequently numerous small abscesses formed in the skin over various parts of the body. The patient was reduced to a mere skeleton, and, notwithstanding all possible care, the whole sacrum became exposed. The more intense symptoms about the hip having subsided, the patient was now turned over to the left side; but in a few days the skin over the great trochanter gave way, and the bone became exposed. He was then propped up so as to rest mainly on the ischiatic tuberosities; and, as the skin here after awhile gave way, he was once more turned on to his back, the sacrum being by this time for the greater part covered over by healthy granulation; and whilst in this position the skin over the various spinous processes of the vertebræ which happened to touch the bed gave way. What with one thing and another, I never saw a patient suffer more intense agony, which was such, indeed, as to necessitate the full administration of chloroform fifty-five times consecutively for the dressing of the various sores; but, notwithstanding all this, he ultimately recovered with an anchylosed hip. The onset in this case was in the early part of the year; and the patient's room, large, lofty, and well ventilated, was in a house in one of our great squares. When this gentleman first came under my care, he was one of the healthiest-looking young men I ever saw, strongly built and most active; and he subsequently was one of the most dashing light cavalry officers in our central Indian compaign.

"Some time after the occurrence of this case, the late Dr. Bence Jones happened to mention to me that he had been summoned into the country to a young gentleman, who was suffering from well-marked pyæmia, without, as far as could be ascertained, any previously existing suppurating surface. I then told Dr. Bence Jones of the above case of pyæmia after gonorrhœa, and begged him to ascertain, if possible, if his patient was suffering from gonorrhœa. The patient died before Dr. Bence Jones saw him again, but at the *post-mortem* examination, the existence of gonorrhœa was clearly proved. A third case of a similar nature, and in a young gentleman, was also mentioned to me by Dr. Guéneau de Mussy.

"Such, gentlemen, are the cases of pyæmia, occurring in private practice, to which I wished to direct your attention. They are twenty-three in number, and twenty-one of them fell under my own notice; the remaining two, the last being well authenticated, have been alluded to simply on account of their extreme rarity.

"And now, if we proceed to analyze the circumstances under which pyæmia occurred in these twenty-three cases, it will be found that an operation was performed in six instances only. In four of these, the first four, the operation was of the most trifling nature—a single-thread seton, a small wart on the heel, a small wart on the scrotum, a small sebaceous tumour of the scalp; and it was only in the remaining two that the operation was of a somewhat severe character—amputation of the breast. Moreover, the first four were all in different years, and not in the same locality; the last two were in the same year, and within a month of each other; but one was in town, and the other in the country. And here let me note, that the third case is also mentioned among those of recovery, this patient having had two attacks of pyæmia at several years' interval, and in different localities.

"Of the remaining seventeen cases, in which no operation had been performed, there was a broken surface in eleven,

and in six there was not even an abrasion. Of the eleven cases in which there was a broken surface, it was but small in ten; ulceration of a small sero-cystic tumour of the breast in one, of abscesses in two, of tonsils in two, of bowel in typhoid fever in three, a needle broken in the leg, a small splinter of wood in the great toe. The eleventh case was the only severe one—compound dislocation of the elbow. The six cases in which there was no abrasion were—a slight injury to the foot followed by suppuration, inflammation of the lateral sinus and internal jugular vein in connection with discharge from the ear after measles, abscess after parturition, and gonorrhœa in three. Of these seventeen cases, none occurred at the same period, or in the same locality.

"As to locality, of the twenty-three cases, sixteen occurred in town and seven in the country. Of the sixteen in town, all, with one exception, that of the young girl who, after running a needle into her leg, was admitted with pyæmia into the hospital, were in the best part of the town, scattered about in good houses, and in good-sized, well-ventilated bedrooms, and well cared for; in fact, to all appearances, under most favourable conditions. The country cases, seven, were in different parts, and widely separated from each other; and their conditions, too, were in all respects apparently excellent.

"As to age, the youngest patient was six, and the oldest close upon eighty. Of the remaining twenty-one, eleven were between fifteen and twenty-five, and ten between thirty and fifty.

"As to local treatment, it was out of the question in several of these cases, and in several cases, too, all possible care and supervision on the part of the surgeon would have been of no avail. Of the twenty-three cases, eleven were under such circumstances.

"In conclusion, pyæmia, it has been said, is caused, for the most part, by hospital-air, by foul air consequent upon the aggregation of surgical cases in the wards of our large hospitals; but pyæmia occurs also in cases even when placed under the most favourable conditions—perfect isolation, large airy rooms in the country, with plenty of fresh air, and in every way well cared for. Pyæmia appears, too, at times to be connected with atmospheric conditions; several cases occurring without any apparent cause, at, or about, the same period in different places. The two cases of amputation of the breast, which were within a month of each other, followed exactly the same course; one, however, being in town, and one a few miles out of town. And at the same time that these cases were under my care, other cases of pyæmia, which occurred in private practice at the same period, subsequently came to my knowledge.

"Moreover, cases occur in which patients are apparently prone to pyæmia; as in the case of a gentleman who recovered from an attack of pyæmia, and a few years afterwards died of another attack.

"The truth is, the causes of pyæmia are still to be worked out."—*British Medical Journal*, Jan. 31, 1874.

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### HOSPITAL NOTES AND GLEANINGS.

*Necrosis of Os Calcis; Removal of Sequestrum by Bloodless Method; Remarks* by Sir W. Fergusson.—The bloodless method is especially valuable in operations like the subjoined, where the manipulations have to be carried on in tissues in close proximity to such important structures as the ankle-joint. The absence of hemorrhage allows of a complete inspection of the diseased part, so that the surgeon can readily ascertain what he is cutting.

F. G——, a clerk, aged twenty-seven, was admitted November 6, 1873, with disease about the right ankle-joint. In January last, from no assignable cause, a slight red swelling appeared on the outer and back part of the right heel, which caused much pain and made the patient lame. The swelling increased in size, and burst in May, and discharged a quantity of offensive matter. Since this he has been laid up, and there has been a constant discharge. The pain has been

less, and only occasional. He has always enjoyed good health, and there is no history of syphilis.

On admission, there was a sinus on the outer side of the right heel, an inch and a quarter behind and below the external malleolus. The opening was surrounded by fungoid granulations, and a probe passed in through it led directly to rough bone at the posterior part of the os calcis, which was evidently diseased. The ankle-joint was quite healthy; no impairment of motion.

Nov. 8th.—Chloroform was administered, and the elastic bandage and India-rubber piping were applied according to Esmarch's method for temporarily arresting the circulation. Sir William then enlarged the sinus with a probe-pointed bistoury, and, after using the cutting pliers, elevator, and sequestrum forceps, removed an irregular piece of necrosed bone about an inch in diameter, representing the whole of the posterior part of the os calcis, which was lying comparatively loose in a cavity partly formed of new bone. After removing the India-rubber tubing there was only slight hemorrhage, which soon ceased; and the wound was filled with oiled lint and covered with water dressing.

Sir William remarked that necrosis of such a bone as the os calcis was not so common as caries, although it was not unusual to find a small piece of necrosed bone lying in a carious cavity. It was rather remarkable that, although the whole of the posterior part of the bone had necrosed, there seemed no interference with the attachment of the tendo Achillis. Probably the deposit of new osseous matter thrown out had been sufficient for its support.

Nov. 14.—No constitutional disturbance; wound looking healthy. The cavity is rapidly filling up.

Dec. 6th.—Wound nearly healed.

20th.—Will leave hospital in a day or two.

In making some remarks on bloodless operations, Sir William began by saying that the method of temporarily suspending the circulation, which had just been adopted, was that specially devised by Professor Esmarch, but that the principle was not new; that a somewhat similar process had been carried out in India years ago in cases of removal of large scrotal tumours; and also that it was the frequent practice of surgeons in this country, when about to amputate a limb, to hold it up above the rest of the body for some time before the operation to allow a great portion of the blood to gravitate out of it. He then observed that this was quite a revolution of the practice of the older surgeons, who would have been horrified at such a proceeding as this, since they were in the habit of taking ten, twenty, or thirty ounces of blood from a patient before his undergoing any capital operation. But at the same time Sir William thought that some arguments might be reasonably brought against the uniform adoption of this method; that though there were many cases in which patients could not afford to lose a drop of blood, yet there were others—for instance, in those of amputation in the thigh—where the sudden addition of so large a quantity of blood as that contained in the limb to the rest of the circulation might be more injurious than the loss of some part of it with the limb when removed. He further observed that this bloodless method had been tried by his colleagues with no bad results at present, but that there had not been sufficient time to note whether there was any difference in the progress of wounds after its use. In operations for necrosis especially, this method greatly facilitated the manipulations of the surgeon. Previously the hemorrhage, from the vascular structures cut through, so obscured the part that the sense of touch was the only guide to the operator; but now the surgeon could see the sequestrum, ascertain its extent, and easily distinguish it from its new bony casing.—*Lancet*, Jan. 3, 1874.

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*Turpentine in Pyæmia; Recovery.*—A workman was admitted into St. Leonard's Hospital, Sudbury, under the care of Dr. J. S. Holden, who had sustained a severe laceration with fracture of two metacarpal bones, from the passage of a truck-wheel over his hand. A few days after the

necessary operation, in which an effort was made to save some of the fingers, gangrene set in, and a secondary operation was performed about the wrist. This was shortly followed by rigors, profuse sweats, sleeplessness, low delirium, subsultus, and stupor, the wound becoming sloughy and offensive. In spite of free stimulation the man was evidently rapidly sinking under the fatal disease—pyæmia. As a *dernier ressort*, half-drachm doses of turpentine were administered in egg emulsion every four hours. After the third dose it was discontinued, as a remarkable improvement had taken place: the pulse and the temperature had fallen, the consciousness returned, and the patient took liberally of brandy and beef-tea. The favourable change was, however, of brief duration, as the day following all the asthenic symptoms reappeared, and the patient relapsed into a comatose condition. The turpentine was again had recourse to in the same doses, and with the same happy effect; but this time the improvement was permanent. All other danger passed by, and the patient made an excellent recovery.

During the height of the attack the sound arm became much swollen and suspicious-looking of purulent mischief. This subsided from the commencement of the turpentine treatment. No abscess formed. Under carbolic-oil dressings the wound granulated rapidly, and the man was soon able to be out.

That the antiseptic and stimulating effect of the turpentine was the means of rescuing this patient from a fatal disease seemed so apparent that it is worthy of more extensive trial in hospitals, where pyæmia so often adds to the mortality after operation.—*Lancet*, January 31, 1874.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*The Siamese Twins.*—These xiphopage monsters, Chang and Eng Bunker, were born in Siam, in 1811, and lived for many years on their plantation in North Carolina, where they died January 17. Chang suffered from lung disease, but the immediate cause of his death is supposed to have been cerebral blood-clot, and Eng is thought to have died, about two hours later, from fright.

At a meeting of the College of Physicians of Philadelphia, held on the 18th of February, Drs. Wm. H. Pancoast and Harrison Allen, the committee of the College entrusted with the post-mortem examination of the twins, presented a preliminary report of their dissection, which was in brief to the following effect:—

The twins were found to be united at the ensiform cartilage by a band about four inches long, and eight inches in circumference. Upon exploring this band through the abdominal cavity, it was found that in Eng the peritoneal cavity extended by a pouch into the band, and terminated there, a short distance beyond the median line; and in Chang two peritoneal prolongations or pouches were found, also extending into the band beyond the median line, and overlapping, one above and the other below the single peritoneal pouch of Eng.

In regard to the vascular connection it was found that on throwing coloured plaster injection into the portal circulation of Chang it flowed through the vessels of the upper part of the band into the portal vessels of Eng. The hypogastric arteries were found to run upward in each body into the band, and were lost in their way toward the common umbilicus in the anterior inferior surface of the middle of the band. Subsequently it was found that the two livers, which were supposed to be joined only by bloodvessels, were really one body, the parenchymatous tissue being continuous between them, so that when they were removed from the bodies and placed on the table they formed one mass. The so-called tract of portal continuity is, therefore, liver-tissue. Chang was supposed to be possessed of one more pouch than Eng. When the liver was removed, however, an upper hepatic pouch was found also proceeding from Eng, so that the band contained four pouches of peritoneum, besides liver-tissue. The examination is still progressing, and a further report will be made at a later date.

In the No. of the *Medical Examiner* (Chicago), for Feb 15th, last, there is reported the dissection, by Prof. Andrews, of a twin monster, attached similarly to the Siamese twins, but the attachment was more extensive, commencing at the common umbilicus and extending upwards to near the point of the sternum. "On opening the parts, the livers were found to be firmly attached to each other, so that it might be correctly said, that there was one common double liver extending across from one body to the other. Below the connecting mass of hepatic tissue, the two abdominal cavities were separated by a thin peritoneal septum, which, however, had an oval opening of considerable size through it, so that the two cavities communicated freely with each other. The stomach and intestines had no connection; and the hearts and lungs were, in like manner, entirely separate."

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*A Stomach Tube swallowed and on the following day rejected.*—Dr. J. B. S. Jackson exhibited to the Boston Society for Medical Improvement (*Bost. Med. and Surg. Journ.*, Jan. 1, 1874) the tube, and made the following report of the case.

The patient was a married woman, 45 years of age, suffering from acute mania, and had been fed with a stomach tube three times daily for about a week. The tube that was used was of the ordinary kind, but had been cut down to fifteen inches in length, and there was tied to it a piece of common rubber tube, about five inches in length, and that connected it with the syringe. At 1 P.M. on the day on which the accident occurred, food was given as usual, and the struggles of the patient were so violent that her physician required the help of three assistants to manage her. The operation being over, and the syringe detached, he proceeded to remove the tube, when he found, to his dismay, that it had slipped off from its attachment. Every attempt was made, with the fingers and with the forceps, to seize it, but without effect. Four hours afterwards, Dr. Hodges saw her, and, after the passage of the long œsophageal forceps, and of a probang entirely into the stomach, without feeling the tube, he felt that it must have passed down into the stomach, though from the result this could hardly have happened. Nothing, of course, was to be done, and the case was left to nature, but without any idea of its expulsion, unless it should first traverse the whole course of the intestine. The following night was passed more comfortably than usual, though when the patient was awake, there was occasional retching, and, the next morning, between 8 and 9 o'clock, this was quite urgent. At 9 A.M. a stomach tube of full length was again passed, food was given, and, on withdrawing the tube, the lost one came up and almost side by side with it, the upper or cut extremity of the tube coming up in advance. The retching was, of course, at once relieved, and on the second day the patient began to take her food in the natural way. The tube, when first expelled, was lead coloured, but, on drying, it resumed its usual appearance, and it may now be seen in the museum of the Medical College, as a donation from the attending physician.

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*Chloroform in Dentistry.*—At a late meeting of the Society, the following resolution was almost unanimously adopted:—

"*Resolved*, That, in the opinion of the Massachusetts Dental Society, the use of chloroform in dental operations is inadvisable."—*Boston Med. and Surg. Journ.*, Dec. 18, 1873.

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*Library of the College of Physicians of Philadelphia.*—The total number of books in the Library of the College is 16,943, exclusive of 1274 duplicates. The increase during the year was 758. The Lewis Library contains 4179 of these volumes, an increase of 162.

Among the donations to the Library worthy of special mention were a number of books from the collection of the late Prof. Samuel Jackson, some valuable quarto and folio works on anatomy belonging to the late Prof. Casper Wistar and presented by the widow of his son Dr. Mifflin Wistar, and a number of works

on diseases of children from Dr. Charles S. Wurts.

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*The Journal Association of the College of Physicians of Philadelphia.*—This Association during the last year numbered 78 members, and has for its object to obtain for the present and future use of the Fellows contemporaneous periodical literature. During the past year there were regularly received 9 English, 3 Canadian, 6 native, 10 French, and 8 German journals. The Association commends itself to the favourable consideration of the Fellows of the College and merits their support.

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*Vermont Medical Journal.*—This is the title of a new bi-monthly medical journal, edited by Dr. J. M. Currier, of which we have received the first number. The editor states that his aim is to make it a repository of original contributions mostly from men of his own State, and of only such medical news as shall pertain to the profession of Vermont. It is not intended to republish articles from other periodicals, nor to make extracts from them.

—

*The Chicago Journal of Nervous and Mental Disease.*—This is the title of another new medical journal, edited by Drs. J. S. Jewett and H. M. Bannister, to be issued quarterly, of which the first number is now before us. Its leading purpose is to collect from all accessible sources the latest and most useful information in regard to the nervous system and mind, both in health and disease.

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Obituary Record.—Died, February 8, 1874, aged 73, Henry Miller, M.D., President of the Louisville Medical College, and formerly Professor of Midwifery in that Institution.

—— in Philadelphia, of phthisis pulmonalis, January 6, 1874, aged 50, S. W. Butler, M.D., Editor of the Medical and Surgical Reporter.

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## FOREIGN INTELLIGENCE.

*Treatment of Typhoid Fever.*—M. Béhier in his opening lecture described his method of treatment of typhoid fever. His treatment consists of hydrotherapy and alcohol, which, with certain exceptions, he employs indiscriminately in all cases of typhoid fever. He avers that he is an enemy to uniformity of treatment in any affection; but, as he has found nothing better than the above in typhoid fever, he feels himself justified in continuing the practice, much to the dismay of the patients unaccustomed to this system of treatment, and of French physicians in general, who look upon it as cruel and irrational. He then went on to explain the *rationale* of the above treatment, which, he said, was refrigerant in the true sense of the word; and, although he would not push the cold baths to the extent of the German doctor (Brand) of Stettin, who administered, on an average, six or eight baths a day to his typhoid patients, yet he thought that one a day, or one in two days, as practised by some physicians, was simply absurd. M. Béhier prescribes three baths a day, at a temperature of 68 degs. Fahr., in which the patient remains fifteen or twenty minutes at a time. Dr. Brand, with the exception of intestinal perforation, admits of no contra-indication in any condition of age or sex for the employment of the cold bath in this affection; but M. Béhier is a little more prudent, and to intestinal perforation he would add old age, pregnancy, menstruation, as conditions in which it would be unsafe to employ the cold bath. In every other case, however, without distinction of age or sex, M. Béhier has recourse to this heroic remedy in typhoid fever, even in pulmonary complications; and, although he does not go so far as the German physician—as to look upon it as a specific in this affection—yet it has proved almost infallible in his hands. As for the alcoholic part of the treatment, he stated that he would not stop to inquire whether the alcohol acted as food or as medicine, as this much-vexed question is far from being settled; but, from his own clinical experience, he has found it an invaluable remedy in typhoid fever and in all inflammatory affections, whether acute or chronic. In typhoid fever, he prescribes

eighty grammes (about two and a half ounces) a day of brandy, with an equal quantity of water, which is administered in divided doses in the twenty-four hours. This, in the Paris hospitals, is called Todd's mixture, and was first introduced by M. Béhier into French practice.

Professor Sée, however, is not so enthusiastic as to the curative powers of cold baths and alcohol in typhoid fever; he employs both with great reserve, contenting himself with an occasional cold bath, or sponging the body of the patient with vinegar and water, and, instead of brandy, he prescribes wine and water, administering, at the same time, small and repeated doses of quinia.—*British Medical Journal*, December 27, 1873.

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*On Cases of Temporary Albuminuria, the result of Cold Bathing.*—At a recent meeting of the Clinical Society of London, Dr. George Johnson read a paper on this subject. (*Med. Times and Gaz.*, Dec. 13, 1873.) The first case was that of a medical student, aged 22, who, about noon on June 19, after bathing for a quarter of an hour in the Marylebone Bath, had a sense of fatigue and headache. Four hours after the bath the urine was tested and found albuminous. In the evening there was still a trace of albumen. The next day the urine was normal, and continued so until June 28, when he again bathed. The bath was again followed by headache, and in the course of the day the urine was found albuminous. From that date until July 17, every specimen of urine passed was tested, and albumen was present at some period of the day on all but five days. Since July 17 the urine has remained normal. The subject of these observations is in good health, and has never been seriously ill. The second case was that of a medical student, aged 25, who, one day in July, bathed in the Lambeth Bath for an hour. He felt no inconvenience. The urine passed an hour after the bath contained a sixth of albumen. The urine was not tested again for three or four days, when it was found normal. The experiment has not been repeated. The third case was that of a medical student, aged 23, who, on three occasions, found his urine normal before bathing in the sea in August and September, and on each occasion, after remaining in the water from a quarter to half an hour, found a moderate quantity of albumen in the urine. In a few hours this had disappeared. He felt no inconvenience from the bathing. Four other students, after bathing from half an hour to an hour, and on one occasion for an hour and a half, found no albumen in the urine. The fourth case was that of a boy, aged 16, looking pale and feeling languid, who was found to have albumen in the urine to the extent of one-eighth on June 28. It was of pale colour, and contained no casts. On September 23, when next seen, only a trace of albumen remained. On October 23 the urine was quite normal. Until within a few days of the time when the albuminuria was first discovered, he had been bathing almost daily in the sea from half to three-quarters of an hour at a time. He had felt fatigued and chilled, and on one occasion had vomited after coming out of the water. The only previous illness had been diphtheria ten years before. The transient albuminuria is believed to have been caused by the repeated and prolonged immersion in cold water; and it is suggested that, as acute Bright's disease is not unfrequently excited by exposure to cold and wet, there is danger lest the frequent recurrence of temporary albuminuria, the result of prolonged cold bathing, and the consequent repression of the cutaneous secretion, may lead to permanent mischief and to structural degeneration of the kidney.

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*Poisoning by Wine of Colchicum.*—Dr. G. W. Major states (*Canada Med. and Surg. Journal*, December, 1873) that a flask of wine of the seeds of colchicum (U. S. P.) was stolen from an express van, and portions of it drunk by seventeen persons, of whom seven died and ten recovered. The quantities taken by each person varied; in the fatal cases from 3 to 10 ounces, and in those who recovered from one mouthful to, in one case, eleven ounces. The ages of the patients varied from 3 years to 45 years.

"In from 45 minutes to one hour and

a half after taking the wine, vomiting ensued. The contents of the stomach were first rejected, then bile or mucus; afterwards a fluid similar to "rice water" of cholera.

"When the amount of poison taken was very great, the purging came on simultaneously with the vomiting—but if only a small quantity, comparatively speaking, had been swallowed, the evacuation of the bowels was delayed for several hours. The passages were first the natural feces, then bilious stools, next "rice water,"—a very large amount of a frothy, slimy secretion, compared by one of the patients to clean soapsuds. In no case were there any traces of blood to be found. The vomiting continued until the last moment in the fatal cases, and the bowels were emptied involuntarily. Cramps were severe in the stomach, bowels, and legs. Severe pains were felt in the knee joints in some, and in two cases very markedly in the left shoulder, so much so, indeed, as to be a continual cause of complaint, and avoidance of lying on the left side. Rubbing was frequently demanded for relief. In the majority there was numbness from the elbow to the wrist; cramps of the fingers, especially the second finger, and in one case extreme numbness of the thumbs under the nails. This latter peculiarity was present even for twenty-six days after. In the case of the boy Thyer, there was great pain between the shoulders. The features (twenty hours after the accident) were pinched and drawn, lips and nose blue, as also the lobes of the ears. The eyes were congested, pupils dilated slightly; voice hoarse and husky, and pain was experienced in speaking.

"Feet and lower extremities icy cold, as also were the hands and arms. The rest of the body had a warmish clammy feel, but was below the normal temperature. The pulse was rapid, 125 to 145 or more in the minute, small, compressible, intermitting, and at times imperceptible at the wrist, though it could be found at the elbow with some trouble. The temporal arteries were difficult of detection; even the carotids required patience to distinguish. For several hours before death, they were almost pulseless, the heart's impulse was not to be felt over the chest, and even with difficulty heard on applying the ear to the chest wall. The sound might be likened to a blowing sound, or a murmur, or to a heart heard at a very great distance, or through a stone wall, both sounds lapsing into one.

"Respiration was full and easy, and was well maintained throughout. The pulse respiration ratio was borne out throughout.

"The sufferers were sensible to the last and throughout. One case terminated with a slight convulsive effort. All sat up before dying, falling back in less than an instant. No headache was complained of. Muscular strength was retained. They were all able to sit up, lift a cup to their lips, or even walk.

"They were perfectly sleepless. In two recoveries there appeared a pustular eruption on the face and lower extremities, resembling in its character poisoned wounds.

"In the case of the boy Thyer, while sawing wood, an hour after drinking the wine, he was seized with violent retching and vomiting succeeded by a 'fit,' which from the description resembled a convulsive attack. Thumbs were turned in, with the fingers closed over them."

The symptoms in every case were proportionate to the amount of wine taken.

All the fatal cases terminated in from 19 to 28 hours.

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*Deaths from Chloroform.*—Two cases of this have recently taken place in New Zealand. One occurred in the Provincial Hospital in a man suffering from epithelial cancer of the lip; the second in Dunedin Hospital during an operation for removal of cancer of the breast.—*Brit. Med. Journ.*, Jan. 31, 1874.

In the *Lancet* for January 17, 1874, is reported the following case, which occurred at the Bristol Royal Infirmary:—

Albert T——, mason, aged 30, was admitted with stricture. It was decided to place him under the influence of chloroform, to try to introduce an instrument. Heart sounds were perfectly healthy. Two drachms of chloroform were administered in a sponge tent with a large hole

at the top. Violent muscular spasms were shortly produced; he began to hold his breath; his face became livid. Artificial respiration by Silvester's method was tried, and continued for three-quarters of an hour, as a faint flickering pulse was felt at the wrist when the movement of the arm became less violent. The heart never recovered its action.

Post-mortem examination showed the right side of the heart gorged with fluid blood, but otherwise quite healthy. The lungs were deeply congested.

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*Millie-Christine.*—These two girls, joined together at the sacrum, who were exhibited a few years since in this country, are now on exhibition in Paris; and MM. Tardieu and Robin communicated to the Académie de Médecine, Jan. 13th, the results of their examination of this monstrosity. Much opposition was made to the examination by the exhibitors ("the Barnums") and only succeeded through a written order of the Prefect of Police.

They were permitted, however, to strip the girls only as far as the hips, but they ascertained some interesting particulars.

The two girls, 22 years of age, are united at the sacrum. The upper portions of the bodies are separate; they have two hearts, which do not beat in unison, and the radial pulse in the two is not isochronous, while there is complete synchronism in the pulsation of the arteries of the lower extremities in both subjects. The sensibility of the upper limbs is distinct and separate in each subject, while any impression on the lower limbs is felt at the same time by both subjects. MM. T. and R. endeavoured to persuade the girls to permit an examination of their pelvic region, and one seemed inclined to assent, but the other most indignantly refused, showing each had her own independent will.

The woman who attends these children stated that they menstruated regularly at one and the same time; and they experienced a desire for defecation and micturition at the same time.

M. Broca added some interesting particulars. He thinks that there exists a certain degree of fusion of the extremities of the two spinal marrows. He observed the degree of sensibility of the lower limbs not to be the same in both subjects. It is obtuse in one of the twins when an impression is made on the lower limbs of the other. There is also an inequality in the length of the lower limbs of the twins. M. R. does not believe all the statements of the woman who attends the twins. It is certain that they have a single anus and probably a single rectum, but M. B. does not believe they have a common vagina. Observations made upon similar malformations show that there generally exist two vaginæ, two hymens, and two urethras. The uterus is also generally double.—*L'Union Médicale*, 15 Jan. 1874.

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*Disease-Destroying Tree.*—M. Gimbert, who has been long engaged in collecting evidence concerning the Australian tree *Eucalyptus globulus*, the growth of which is surprisingly rapid, attaining besides gigantic dimensions, has addressed an interesting communication to the Academy of Sciences. This plant, it now appears, possesses an extraordinary power of destroying miasmatic influence in fever-stricken districts. It has the singular property of absorbing ten times its weight of water from the soil, and of emitting antiseptic camphorous effluvia. When sown in marshy ground it will dry it up in a very short time. The English were the first to try it at the Cape, and within two or three years they completely changed the climatic condition of the unhealthy parts of the colony. A few years later its plantation was undertaken on a large scale in various parts of Algeria. At Pardock, twenty miles from Algiers, a farm situated on the banks of the Hamyze was noted for its extremely pestilential air. In the spring of 1867 about 13,000 of the eucalyptus were planted there. In July of the same year—the time when the fever season used to set in—not a single case occurred; yet the trees were not more than nine feet high. Since then complete immunity from fever has been maintained. In the neighbourhood of Constantine the farm of Ben Machydlin was equally in bad repute. It was cov-

ered with marshes both in winter and summer. In five years the whole ground was dried up by 14,000 of these trees, and farmers and children enjoy excellent health. At the factory of the Gue de Constantine, in three years a plantation of eucalyptus has transformed twelve acres of marshy soil into a magnificent park, whence fever has completely disappeared. In the island of Cuba this and all other paludal diseases are fast disappearing from all the unhealthy districts where this tree has been introduced. A station-house at one of the ends of a railway-viaduct in the Department of the Var was so pestilential that the officials could not be kept there longer than a year. Forty of these trees were planted, and it is now as healthy as any other place on the line. We have no information as to whether this beneficent tree will grow in other than hot climates. We hope that experiments will be made to determine this point. It would be a good thing to introduce it on the West Coast of Africa.—*Med. Times and Gaz.*, Nov. 1, 1873.

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*New Journals on Gynœcology.*—Two of these are announced as about to appear in Paris—one, entitled *Recueil de Gynécologie*, to be edited by M. Gallard and Prof. Pajot; the other, *Les Annales de Gynécologie*, edited by M. Lauwereyns.

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*Galvano-Caustic.*—MM. Legros and Onimus assert their experiments show that the eschar caused by the use of galvano-caustic in the peritoneal and pleural cavities is innocuous, and that this mode of cauterization is preferable to other processes for the removal or cauterization of organs contained in these cavities.—*La Tribune Med.*, Feb. 1, 1874.

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*Electro-Therapeutics.* — Unfortunately, electro-therapeutics form no exception to the rule that treatment rests on a foundation far less scientific than does the diagnosis of disease. The progress of our knowledge of healthy and morbid states of the nervous and muscular systems has not been followed by a coextensive increase in our knowledge of their appropriate electrical treatment. Something has been done to bring practice up to theory, but it must be confessed that much of the early promise of electro-therapeutics still awaits fulfilment. Within the range of medicine proper its sphere has been little extended. Those of its applications which were of doubtful value fifteen years ago are for the most part of doubtful value still, and its generally recognized utility hardly extends beyond the morbid states of nerve and muscle.—*Lancet*, Jan. 10, 1874.

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*Homœopathy.*—The opinion of the Faculty of the University of Naples was recently asked as to the propriety of having homœopathy taught in that University. The following admirable reply was given:

"The University of Naples is not a proper field for instruction in homœopathy, because the rational medicine which is taught here based on the natural sciences excludes allopathy as homœopathy, or any other absolute system or *dogma*. The study of rational medicine is as far removed from the ancient allopathy with its blood-letting and purgation, as from the recent delusion of homœopathy with its ridiculous infinitesimal doses and *similia similibus* medication."

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Obituary Record.—Died, at Venice, aged 63, Dr. Namias, one of the most distinguished of Italian physicians.

——At London, of cerebral hemorrhage, on the 22d of January, aged 31 years, John Jones Phillips, M.D., Assistant Obstetric Physician to Guy's Hospital, and contributor of several valuable memoirs to the Transactions of the Obstetrical Society of London, and to Guy's Hospital Reports.

—— Dr. Max Schultz, Professor of Anatomy in the University of Bonn, is reported to have died suddenly from heart disease.

—— In Paris, December 25th, 1873, aged 40, M. Charles Legros, one of the most patient and conscientious of the young French physiologists. He was a pupil of M. Robin, and latterly the co-worker of that eminent histologist.

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I regard Barnes as one of the ablest men in his department. I am not sure but since the death of Simpson, he is the leading gynæcologist of the day. I shall, therefore, take great pleasure in commending the work to my class.

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From Prof. A. H. KOLLMEYER, *Univ. of Bishop's Coll., Montreal.*

I shall take great pleasure in recommending it to my classes, both at the University of Bishop's College, and in the Quebec College of Pharmacy. I consider it the most concise and complete work of the kind that I have ever seen, and think that every physician and pharmaceutist should possess one.

From Prof. J. S. WELLFORD, *Med. Coll. of Virginia.*

I have carefully examined it, and find that its old merits have been retained, and the additions by the present editor have certainly rendered it *au courant* with the present condition of our literature. Such practical works as this are very much needed by the busy practitioner.

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We are glad to see a new edition of this invaluable work, and to find that it has been so thoroughly revised, and so greatly improved. The dictionary, in its present form, is a medical library in itself, and one of which every physician should be possessed.—*N. Y. Medical Journal*, Feb. 1874.

With a history of forty years of unexampled success and universal indorsement by the medical profession of the western continent, it would be presumption in any living medical American to essay its review. No reviewer, however able, can add to its fame; no captious critic, however caustic, can remove a single stone from its firm and enduring foundation. It is destined, as a colossal monument, to perpetuate the solid and richly deserved fame of Robley Dunglison to coming generations The large additions made to the vocabulary, we think, will be welcomed by the profession as supplying the want of a lexicon fully up with the march of science, which has been increasingly felt for some years past. The accentuation of terms is very complete, and, as far as we have been able to examine it, very excellent. We hope it may be the means of securing greater uniformity of pronunciation among medical men.—*Atlanta Med. and Surg. Journ.*, Feb. 1874.

**HENRY C. LEA—Philadelphia.**

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Lecture on Chloral as an Anæsthetic during Labour.* By W. S. PLAYFAIR, M.D., Prof. of Obstetric Medicine in King's College, Physician for Diseases of Women and Children to King's College Hospital, and Examiner in Midwifery to the Royal College of Physicians.

"The means at our disposal for lessening the sufferings of our patients during labour must always be a subject of great practical interest to the accoucheur. The administration of chloroform during the second stage has become so established a custom among many that it is perhaps hardly necessary to say much with regard to it. The more experience, however, I have of its use, the less, I feel bound to say, do I like it as an anæsthetic during labour; and this, not because it does too little, but on account of its tendency to do more than we wish. While in certain cases, when given with judgment, only during the pains, and not until these have become strong and forcing, it answers admirably, soothing the patient's suffering without retarding her labour or producing complete anæsthesia; in others, it has an unquestionable tendency to diminish the force and frequency of the uterine contractions. I know not what may have been the experience of others, but my own certainly is that in a large number of cases it has a very marked effect in diminishing the strength of the pains, and thereby very materially lengthening the continuance of the labour. Over and over again, when the administration of chloroform has been commenced, I have observed the character of the pains completely to alter, and again recover their

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former efficiency as soon as the inhalation was suspended. Besides this, I have no doubt that a very continuous use of chloroform during labour has a marked effect in predisposing to post-partum hemorrhage, inasmuch as the tendency to undue relaxation of the uterine fibres continues for a time after the birth of the child. Although I by no means intend by these remarks to advise you not to use chloroform during labour, I certainly do think that it ought to be given with a greater degree of caution, and perhaps more sparingly, than the recommendations in many of our text-books would lead you to believe to be needful. The susceptibility of patients to its action seems to vary much, and therefore it is all the more necessary that its effects should be carefully watched in each individual case, and the amount administered regulated accordingly.

"While, in my judgment, chloroform is apt to be too freely and incautiously used, the administration of chloral as a means of lessening the pains of labour is, I think, by no means as yet appreciated at its proper value. It has this immense advantage over chloroform, that it does not seem to diminish the strength and intensity of the pains, while it very markedly diminishes their painfulness. It has also another great recommendation, that it is chiefly applicable at a period when we would not think of administering chloroform—towards the termination of the first stage of labour, before the complete dilatation of the os, and when the sharp grinding pains perhaps produce more suffering and are less easily borne than the more forcing pains of a later stage. There is a type of labour very common, especially in women of a highly-developed nervous organization, such as constitute a large proportion of our patients among the higher classes, in which I have found it to be specially valuable. In these, before the rupture of the membranes and the complete dilatation of the cervix, the pains are very severe, but short and ineffective, chiefly limited to the back, and producing little or no effect in dilating the os. Hours and hours of really intense agony often elapse, until the patient is wearied and exhausted by her fruitless sufferings. In cases such as these, a common and very useful practice has been to administer a considerable opiate, so as to produce some hours of refreshing sleep, after which we expect the labour to recommence with fresh vigour and effect. The disadvantage of this plan, however, is that during the action of the remedy the labour is suspended, and much time is thus lost. If, however, chloral is administered instead of the opiate ordinarily employed, the probabilities are that the same refreshing rest will be obtained without any suspension of the pains or protraction of the labour. The character of the uterine contractions will be observed to alter; they will become steady and useful, but they are not suspended. Another condition frequently associated with the former is rigidity and spasm of the cervix. Very generally in this class of cases the cervix is thin and rigid, with a sharp edge. Soon after the chloral has taken effect the tissues seem to relax, and I have not unfrequently observed a thin os, which had remained unaltered in character for many hours, dilate rapidly under the influence of the remedy, far more so than when chloroform is inhaled for this indication. It is not, however, only in cases of this kind, which may be classed among abnormal labours, that the use of the drug is of value, although it finds perhaps in them a more special application. It may, I think, be very generally and advantageously exhibited in perfectly natural labour, for the specific purpose of lessening the sufferings of the patient. When judiciously given the patient falls into a drowsy state, not quite asleep but nearly so. She is roused as a pain begins, but suffers comparatively little; and experienced women, who have the recollection of former labours to guide them, bear strong witness to the immense relief thus obtained. I have given the remedy in this way for the past two years in most cases I have attended, and I have no reason to think that any bad effects have followed its administration. I have very carefully watched the intensity of the contractions, and I have not the least ground for thinking that it has any effect

in diminishing either their frequency or their force.

"The way I give the drug is as follows: I order a six-ounce mixture, containing a drachm and a half of the hydrate of chloral. When the pains are becoming severe, and I deem it advisable to employ the anæsthetic, which is generally not until the first stage of labour is approaching completion, I give one-sixth part of the mixture—*i. e.*, fifteen grains of chloral. This I repeat in about twenty minutes; and usually after the second dose enough has been taken to bring the patient sufficiently under the influence of the remedy. Its further administration must now be regulated by its effects. If the patient is drowsy and relieved, a third dose need not be given for three-quarters of an hour or an hour; and then half the quantity will probably suffice to keep the patient in a sufficiently somnolent state. It is seldom necessary to give more than a third dose; and I have never given more than a drachm of chloral during the entire labour. In this way, lessening the quantity after the second dose, and increasing the intervals between their administration, a full and sufficient effect can usually be kept up for many hours. I feel certain that any who give this method a fair trial will appreciate its value.

"The exhibition of chloral in this way is no novelty. It has, I believe, been recommended more than once in our journals; but, so far as I know, it has never come into anything like general use as an anæsthetic. Bear in mind that it need not at all interfere with the exhibition of chloroform. When the pains get strong and forcing, that may be inhaled just as if chloral had not been given, only a smaller quantity will probably suffice. As our patients suffer less, they are also less urgent in their demands for the commencement of the chloroform inhalation; and thus there will be less likelihood of those evils I have mentioned to you being produced."—*Lancet*, Feb. 21, 1874.

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*Abstract of a Clinical Lecture on a Case of the Employment of the Caoutchouc Ligature.* By Francis J. B. Quinlan, M.D., Physician to St. Vincent's Hospital, Dublin.

"The case under our consideration and lately under your observation, is that of Bridget G——, a healthy, well-nourished country woman, of plethoric temperament, aged twenty-seven years. Upon examining her, we found, at the upper part of the vulval opening, a large vascular tumour, of the size of a very large orange. This tumour was of several years' standing, and bore quite an exact resemblance to a small cauliflower. It was connected with the site of the clitoris by a pedicle resembling the stalk of that vegetable, which was topped with the arborescence of the tumour. From either side of the pedicle descended two hypertrophied labia minora, like enormous cockscombs. The case was evidently one of syphilitic hypertrophy—a diagnosis which was thoroughly confirmed by crops of condylomata around the anus and on the folds of the nates. The cauliflower tumour, which was divided into two portions by a fissure extending to the very root of the pedicle, was evidently the hypertrophied prepuce and frenum of the clitoris, and the peculiar arborescent appearance was attributable to the trabeculæ of the erectile tissue in this part of the labia restraining the hypertrophy of the rest of the tissue, and, by binding it down in bundles, producing the arborescence. The condylomata and the local irritation being reduced by rest and appropriate treatment, the question arose as to the best and safest method of removing this disfiguring hypertrophied mass; and it struck me that the newly introduced elastic ligature would admirably act in the case of this most vascular growth, so liable to cause dangerous hemorrhage. Accordingly, on the 20th of December I ligatured the whole mass with a solid India-rubber cord two millimetres in thickness. I used this solid cord because the result of some previous experiments had satisfied me of the inadequacy of drainage-tube or any other variety of hollow caoutchouc tubing. The solid cord which I used is to be obtained at most India-rubber shops, the only difficulty being to procure it of sufficient thinness; when thicker than I have mentioned, it is unmanageable, especially for small growths. When drawn out to four

times its rest length, this cord is not more than half a millimetre in thickness, and the tension upon half a metre of it is 1230 grammes. It is thus admirably adapted for this gradual ligaturing and cutting process.

"Having etherized the patient, I tightly ligatured the whole mass, tying the knot by the ingenious plan, devised by Sir Henry Thompson, of the addition of a series of ordinary ligature knots of sewing silk to prevent the India-rubber knot slipping. Immediately the temperature of the tumour fell frem 98.3° F. to 96.5°. After a few hours it rose again slightly, and the tumour became very tense. The temperature then fell again rapidly, and the sphacelating process steadily continued until the growth became destroyed.

"The pathological process thus occurring is plain, and it is in this that the great merit of the elastic ligature consists. When it is applied there is a brief interruption of all circulation, but quickly the arterial flow recovers itself, the venous system being still impeded. Great distension of all the capillaries naturally ensues, superinducing a condition of things resembling that which is the cause of varicose ulceration of the legs. The danger of the process (I speak solely from theoretical considerations) appears to be the presence of a mass of gangrenous organic matter immediately opposite a granulating and highly absorbent surface. For this reason in our recent case we kept outside the India-rubber ligature a loose skein of cotton yarn, about the same thickness as the ligature, and well soaked in carbolic oil. This was renewed three times a day, and a piece of lint kept well wetted with a permanganate solution prevented any offensive odour. On the third day it became evident that the ligature was no longer acting, and on examination it was found to be quite loose. You may remember the simple way in which this difficulty was combated. A slender rod of ivory, one millimetre in thickness, was passed through the ligature circle and twisted round a few times, in the manner in which a ready tourniquet is made from a handkerchief tied round a limb with a stick twisted through it. These ivory rods can be had of various thicknesses in the shanks of ivory crochet-needles. Ivory is, I think, the best material, on account of its strength, lightness, smoothness, and rigidity; and by this simple means ligatural pressure can be kept up to the very last to any degree of tightness required. On the fifth day the mass dropped off, leaving a surface which healed up kindly; and, with some constitutional treatment for the syphilitic taint, the patient made a good recovery.

"I would particularly impress upon you that at the time of application, and while it is cutting through the skin, the ligature is painful. For this reason, just before the commencing, we injected hypodermically a quarter of a grain of acetate of morphia in the neighbourhood of the operation, a procedure which much assisted the anæsthesia, and reduced subsequent local pain, by keeping the patient throughout the whole day of the operation in a drowsy quiescent state."—*Lancet*, March 7, 1874.

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## HOSPITAL NOTES AND GLEANINGS.

*New Operation for Cleft Palate.*—In our No. for January last (p. 12), we gave a short notice of Sir Wm. Fergusson's new operation for cleft palate. The result of this mode of operating was not then ascertained, but in the No. of the *Lancet* for Feb. 28th last, we find the following report of four cases successfully treated, with some more minute details of the operation.

"The first steps of this operation are somewhat similar to the old operation for closing the cleft in the hard palate—namely, paring the edges of the cleft, and making an incision down to the bone parallel to, and about a quarter of an inch from, the edge of the cleft on either side, the point of the knife being carried back just as far as the junction between the hard and soft palate. Into these incisions a chisel half an inch broad is inserted, and its edge directed against the posterior margin of the hard palate and made to cut from behind forwards, thus partly detaching a slice of bone on each side, with the soft tissues and periosteum attached to their upper and lower surfaces. The result of this is that the sides of the

cleft fall easily together, leaving a small aperture through the bone on either side. One, two, or, if the fissure be long, three stitches are passed through the lateral clefts by means of an ordinary aneurism-needle, and thus encircle the detached portions of bone and soft tissue, each suture passing through into the nasal cavity. It should be noted that there is no tension on the flaps, the threads merely keeping the parts steadily in contact. The amount of pain and constitutional disturbance is much less marked in the patients that have been treated in this way than when the old operation of dissecting up the soft parts from the bone has been resorted to.

"From the liability of the flaps to twist in slightly, and from the thinness of the edge, Sir William Fergusson is careful to pare the sides somewhat obliquely, in order to present wider raw surfaces for adhesion. The sutures, which are kept in much longer than in the ordinary operation, cause no harmful irritation. The lateral clefts become filled up by new bone, which is rapidly thrown out and tends to keep the parts firmly united in the median line.

"The first case in which the operation was performed was that of a girl aged eighteen, whose soft palate had been closed two years ago, and whose hard palate had been operated on by the old method three times, but unsuccessfully, except that the gap was somewhat lessened in size. Before the operation by the above plan on Nov. 22d, 1873, the cleft was half an inch long and a quarter of an inch wide. Two sutures were introduced, and were removed in seven days. She was discharged at the end of the third week with firm union of the whole palate in the median line, and the lateral clefts closed.

"The second case was also that of a girl of eighteen. The soft palate was closed three years ago. Since then she has undergone two operations for the closure of the hard palate, with only partial success, by the old method. The cleft was oblong, three-quarters of an inch long, and three-eighths of an inch wide. At the operation on Nov. 22d two sutures were passed. The stitches were removed a fortnight afterwards, when there was a slight chink in the middle. The edges were therefore freshened, and a stitch reinserted. This was kept in fourteen days, and she was then discharged with a small pin-hole anteriorly.

"The third case was that of a boy, aged fifteen, previously successfully operated on for double harelip and cleft in soft palate. One unsuccessful operation, followed by erysipelas, had been performed on the hard palate by the old method. Cleft one inch long and one-third of an inch wide. Operation as above on January 24th, 1874. Three sutures were passed. Union has taken place except at the posterior part, where there is a small hole which is slowly contracting.

"The fourth case is that of a boy of fourteen, whose soft palate was closed in May, 1873. Last November the hard palate was operated on by the old method, and the cleft somewhat lessened in size. Before operation on the 7th inst. there was a narrow fissure about half an inch long. The bone in this case was rather difficult to cut. The patient has so far gone on well."

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*Acute Articular Rheumatism treated by Acids.*—In recently making some comments at Guy's Hospital on the treatment of acute rheumatism, Dr. WILKS expressed a considerable distrust of the ordinary methods. He remarked that we do not yet possess an accurate knowledge of the essential cause of the disease, nor of the mode of its operation. We are, in fact, ignorant of the natural history of the disease. Medical practitioners are too apt to be credulous in matters of therapeusis, and are not sufficiently careful always to differentiate between effects and coincidences. Usually, for instance, the diagnosis of acute articular rheumatism is regarded as a sure and certain indication for the exhibition of alkaline remedies, and these remedies are persisted in in every condition or modification of the disease, without the slightest evidence of a beneficial influence resulting therefrom. Nay, it

frequently happens that the more severe the disease the stronger does the belief in the particular remedy become, and medical men not uncommonly allege in support of the efficacy of the treatment that the complications were of the most serious nature. If the patient recover after having had severe heart disease or symptoms referable to an affection of the nervous system, it is regarded as proof positive of the value of the remedy. Whereas we can not only not be certain that recovery did take place as a result of the treatment, but that it did not occur in spite of the vaunted remedies. On the other hand, some have asserted that there is no known cure for acute rheumatism, and that mint-water will answer every purpose. This is Dr. Wilks's opinion, and it was merely to strengthen this view that he gave mineral acids in the subjoined case, never supposing that they would do good or harm. Dr. Wilks maintains that, until we know everything concerning the disease, and especially the relation between the joint affection and the internal complications, we have no scientific basis for the selection of remedies. It is even doubtful whether the subsidence of the arthritic inflammation during the course of the disease is desirable, for in all fatal forms of rheumatism this is usually seen to occur. It may be remarked, however, that sometimes, in cases of internal complication, it does seem as if large doses of potash or of quinia have some influence in arresting the disease. In several cases treated by quinia Dr. Wilks has noticed the urine to become alkaline on recovery, as if this were the natural process of cure; as is seen also in typhoid fever. The same thing occurred in the present case.

G. W——, a well-nourished man, aged thirty-five, was admitted on January 14. A week before this he began to suffer pain in the hip-joints; subsequently both knees, and the right shoulder, wrist, and hand were affected. The pain in the joints was preceded by a feeling of coldness, but there was no actual rigor.

On admission the left knee was swollen from the presence of fluid within the joint. The right hand also was swollen and painful. A systolic bruit could be distinctly heard over the base of the heart, and extending a short way along the aorta. A venous hum was audible at the root of the neck. Perspiration was acid; temperature 101°; pulse 96; respiration 24. Tongue moist and covered with a white fur. The urine was acid, and contained a large quantity of lithates.

Ordered fifteen drops of dilute nitro-hydrochloric acid every four hours, and a diet to consist of milk, bread, and beef-tea.

*January* 16. Temperature 101.8°.

19*th*. Joints previously affected are better, but the right hand and both knees are still painful. Systolic basic bruit still very loud.

20*th*. Temperature 102.8°. Perspires freely.

23*d*. Hands and knees almost well. Temperature 101.2°.

28*th*. None of the joints are swollen, but some feel stiff and sore. Bruit hardly audible. Urine alkaline.

*February* 2. Bruit almost entirely gone. The patient is convalescent.—*Lancet*, Feb. 14, 1874.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Disappearance of Fibroid Tumour under the Administration of Chloride of Ammonium.*—Dr. F. W. Hatch relates (*Pacific Med. and Surg. Journ.*, Nov. 1873) the case of a woman æt. 39, who had a tumour in the abdomen, "extending from the pelvis upwards and to the left side, above the umbilicus," and with neuralgia in the supra-orbital and temporal regions of one side. For the latter affection chloride of ammonium was given to the extent of 60 to 80 grains daily in divided doses. The relief to the neuralgia was very marked and at the same time the abdominal tumour which Dr. H. regarded as a uterine fibroid diminished, and before the end of the year had disappeared.

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*Ligature of Arteries as a Preventive of Destructive Inflammation following Wounds of Joints and Arteries.*—Dr. D. C. Jones relates (*Kansas City Med. Journ.*, Jan. 1874) two successful cases which came

under his notice during his service in the U. S. A.

"After the battle of Sabine Cross Roads, La., the wounded were removed to Grand Ecore, La., a distance of about fifty miles. Many of the wounded suffered from the most violent and uncontrollable inflammation from gunshot wounds of both the upper and lower extremities, which resisted all ordinary measures of treatment. Suppuration in many cases had ceased, and in its place a bloody water was discharged from the openings and abrasions; the swelling in some was immense. Two of the above cases came under my charge. Both were subjects of arterial lesion of the lower extremities, the arteries wounded being the anterior and posterior tibial, two inches above the middle of the leg. Mr. Guthrie's plan of ligation was first adopted, but on the 7th and 11th days secondary hemorrhage ensued, and owing to the extreme tumefaction of the limbs, extending above the knee in both cases, and in one a few small patches of incipient gangrene being detected on the foot, I resolved to make an experimental effort to save the limbs by cutting off the arterial supply of blood, by ligating the femoral artery near the apex of Scarpa's triangle.

"The operation was performed with but little difficulty, and the hemorrhage ceased at once in both cases; the swelling began to decline within twelve hours, and on the fourth day the limbs were nearly of their natural size; the discharge had changed from bloody water to healthy pus.

"One case recovered rapidly, the other slowly, on account of the sloughing out of the gangrenous patches which had shown themselves previous to the application of the ligature; these surfaces, however, granulated healthily and cicatrized firmly, though the suppuration was profuse and long continued."

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*Hospital of the University of Pennsylvania.*—This well-arranged hospital is rapidly approaching completion, and the following appointments have been made in the staff:—

D. Hayes Agnew, M.D., Prof. of Clinical Surgery. John Neill, M.D., Associate Prof. of Clinical Surgery. Wm. Pepper, M.D., Prof. of Clinical Medicine. Wm. Goodell, M.D., Prof. of Clinical Obstetrics. Wm. F. Norris, M.D., Prof. of Ophthalmology. Geo. Strawbridge, M.D., Prof. of Otology.

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*Medical Graduates in* 1874.—

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| University of Pennsylvania | 121 |
| Jefferson Medical College (Phila.) | 151 |
| College of Physicians and Surgeons, New York | 84 |
| Bellevue Hospital Medical College | 181 |
| College of Physicians and Surgeons, Baltimore | 26 |
| Medical College of Ohio | 87 |
| Medical Department of the University of Louisville | 123 |
| Cincinnati College of Medicine and Surgery | 22 |
| Chicago Medical College | 44 |
| College of Physicians and Surgeons of Syracuse, N. Y. | 9 |
| Medical College of the Pacific | 12 |
| Medical Department of the University of California | 8 |

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*Alumni Association of the Medical Department of the University of Pennsylvania.*—This Society celebrated its anniversary on the 11th of March, at the New University Buildings, at Thirty-fourth and Locust Streets. The members assembled in the Chapel of the Department of Arts, whence they proceeded to the new medical department building now rapidly approaching completion, and then to the new hospital of the University, the main building and one wing of which are now nearly completed. A full description of the plan of each of these buildings was given in the number of this Journal for August last.

From the report of the executive committee we learn that the general fund for the hospital consists of $550,000 with $11,261 from Alumni fund, making a total of $561,261.

The following officers of the Society were elected for the ensuing year: President, George B. Wood, M.D.; Vice Presidents, Drs. Jos. Carson, George W. Norris, Isaac Hays, and Meredith Clymer; Corresponding Secretary, Dr. R. A. Clee-

man; Recording Secretary, Dr. Horace Y. Evans; Treasurer, Prof. R. E. Rogers.

Executive Committee—Drs. Hiram Corson, Richard Cooper, Edward Hartshorne, William Hunt, Andrew Nebinger, John H. Packard, H. Lenox Hodge, James H. Hutchinson, James Tyson, William Pepper, W. R. Dunton, S. S. Stryker, William F. Norris, Thomas J. Yarrow, J. B. Howard Gittings, Charles D. Nancrede, Louis Starr, Jerome Longenecker, C. K. T. Miller, Frank C. Hand.

Orator—Cornelius G. Comegys, M.D., of Cincinnati, Ohio.

The annual oration was then delivered by Dr. Claudius H. Mastin, of Mobile, Alabama, after which the annual collation was partaken of in the lower hall.

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*Harvard Medical School.*—We are glad to learn from the *Boston Med. and Surg. Journ.* (Feb. 5th), that the plan of instruction adopted three years ago is proving, as it deserves to, a complete success.

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*Prescription Blank Book.*—The Case-Record Company of Cincinnati has issued a very handy and convenient pocket blank book, for the "busy practitioner." It has on each page a prescription blank with a margin like a check book, for copy of prescription and patient's name and symptoms.

An office edition has also been published containing three blanks, with margins, on each page.

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## FOREIGN INTELLIGENCE.

*Bromide of Potassium in the Treatment of Epilepsy.*—Dr. Thomas Hayden, in a paper on this subject, read before the Med. Soc. College of Phys. (Ireland), related three cases of epilepsy treated by the above article, and made the following remarks in regard to them:—

"None of these cases would warrant the assertion that a cure of epilepsy had been effected, although in all three the condition of the patient has been greatly ameliorated, and in two of them, after an interval of three and six months respectively, there has been no return of the fits, whereas, previously to treatment, they were in one case of monthly, and in the other of fortnightly recurrence. Some examples of alleged permanent cure have been recorded, but in none of them had sufficient time elapsed after the suspension of treatment, to warrant their being so regarded. So much granted, it is, nevertheless, quite indisputable that bromide of potassium is capable of controlling epilepsy in a marvellous manner, considering the hitherto intractable character of that disease. Through its agency the fits are mitigated in severity, the interval between them is protracted, and the nutrition of the nerve-centres is promoted, as judged by the improvement of memory, and of self-confidence, and the cessation of muscular tremor on the part of the patient.

"Drs. Anstie and Jackson are of opinion that its efficacy is limited to a reduction in the number of the fits, and a mitigation of their severity; with the exception of a single case observed by Dr. Anstie, they have not witnessed an example of cure, in the sense of long absence of well-pronounced fits, without the continued use of the medicine at short intervals.

"This is likewise my experience; but surely, even if no more can be claimed for the bromide than this, it will not be argued that in the treatment of so formidable a disease as epilepsy, the inconvenience arising from the occasional use of a medicinal agent by which it can be controlled, and, with more or less of certainty, averted, is a penalty in excess of the advantage gained."

Dr. H. rarely exceeds 30 grs. thrice daily for the dose of the bromide, as he thinks that the full effect of the remedy may be obtained without exceeding that quantity.—*Dublin Journ. Med. Sci.*, Feb. 1874.

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*Injection of Chloral in Tetanus.*—M. Bouillaud, on the part of M. Oré, a professor of the Bordeaux Medical School, related a case to the Académie des Sciences, February 16, in which chloral had been injected into the veins as a remedy in traumatic tetanus. A man after a wound of his finger became the subject of tetanus,

in consequence of which his mouth became so closed that no remedy could be administered. M. Oré therefore threw an injection containing ten grammes of chloral into the veins, which produced peaceful sleep; and this was followed by a second and third injection, with the effect of obtaining a sleep of eight hours.—*Med. Times and Gazette*, Feb. 28, 1874, from *L'Institut*, Feb. 18.

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*Sciatica Promptly Cured by Croton Chloral Hydrate.*—Dr. R. W. Falconer, of Bath, relates (*Brit. Med. Journ.*, Feb. 28) the following case:—

"A lady, æt. 50, of rheumatic diathesis, was suddenly seized with sciatica. The pain was most severe. Two grains of croton chloral hydrate, with enough extractum anthemidis to make a pill, were given. Half an hour after taking the pill, the pain had ceased; there was a very slight return afterwards. With the beneficial effect of the croton chloral hydrate, there was 'some confusion of head, and near objects appeared distant.' She had no pain the following day until the evening; then a sharp attack occurred. Half a pill was given at once, and in twenty-five minutes the pain was gone. She had 'slight confusion of head; no alteration of vision.' There has been no recurrence of sciatica since. The first attack occurred fourteen days ago."

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*Chloral Hydrate and Camphor as a Local Application in Neuralgia.*—It is stated that the intimate mixture of equal parts of chloral hydrate and camphor will produce a clear fluid which is of the greatest value as a local application in neuralgia. Mr. Lenox Browne relates (*Brit. Med. Journ.*, March 7, 1874) that he has employed it and induced professional friends to do so, and that in every case it afforded great, and in some instantaneous relief. "Its success does not appear," he says, "to be at all dependent on the nerve affected, it being equally efficacious in neuralgia of the sciatic as of the trigeminus. I have found it of the greatest service in neuralgia of the larynx, and in relieving spasmodic cough of a nervous or hysterical character." It is only necessary to paint the mixture lightly over the painful part, and to allow it to dry. It never blisters, though it may occasion a tingling sensation of the skin. He has found it also an excellent application for toothache.

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*Aquapuncture in the Treatment of Neuralgia.*—Dr. Siredey has employed aquapuncture for the last three years, for the relief of sciatic, intercostal, and ileo-lumbar neuralgia, and has always found it to produce considerable relief and sometimes a cure by a single application. The process of aquapuncture consists in forcibly projecting with a particular apparatus an extremely fine jet of water upon a point of the skin. This produces at the spot a small raised blister with a minute orifice at its summit, from which flows a fluid colourless or sometimes tinged with blood. After a few hours the blister falls and the following day a small dark scab is found in its place.—*L'Union Med.*, March 3, 1874, from *Bull. de Thérap.*

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*Recurrent Glossitis.*—Mr. A. M. Ward read before the Surgical Society of Ireland, the history of the case of a lady, upwards of 70 years of age, who had been the subject of six successive attacks of glossitis. Having remarked that, so far as he was aware, no case in which inflammation had attacked the tongue more than once had been recorded, Mr. Ward referred to the writings of early and modern surgeons on glossitis. The patient had her first attack in May 1867, without any apparent cause. She had three similar attacks in the same year; each attack apparently exceeding in severity the preceding one. She was treated in the usual manner, viz., by scarification of the tongue, etc., in these attacks, all of which were rapidly recovered from. She had no attack from Nov. 1867 until June 1869, at which time she came under Mr. Ward's care with an attack precisely similar to those she had had previously, and which was immediately relieved by precisely similar treatment. The swelling was entirely confined to the left side of the tongue. The following month, July, she had another similar attack, the convalescence from which was somewhat more

tardy than from the former ones. It was now suggested by Dr. Quinan, who saw the case, that the glossitis might be due to a set of false teeth which the lady wore. She was induced to give up wearing them, and had no further return of the attacks to which she had been so subject. For a long time prior to her death, she suffered from a profuse salivation, without any apparent cause, and had several attacks of lumbago—a complaint which she had not been previously subject to. Mr. Ward called attention to the following points of interest in the case: (1) The frequency of the attacks; (2) their suddenness of access, without any premonitory febrile or constitutional disturbance; (3) the termination of all the attacks in resolution; (4) the rapidity of convalescence after local abstraction of blood; (5) the possibility of the attacks having been due to the wearing of false teeth; (6) the limitation of the swelling to the left half of the tongue; and (7) the absence of all local ill effects.

Dr. H. Kennedy suggested that gout might have been the cause of the glossitis in the case Mr. Ward had detailed. He (Dr. Kennedy) had also seen two cases of glossitis occurring in connection with urticaria.—*Irish Hospital Gaz.*, March 2, 1874.

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*Arrest of Hemorrhage by Flexion.*—At the meeting of the Berlin Medical Society, January 9, Dr. ADELMANN read a paper on "Protracted Flexion as a Means of Arresting Arterial Hemorrhage." He stated that after the account of the success obtained in England and Ireland in the treatment of aneurism of the limbs by flexion, he had taken great pains in ascertaining how far advantage would result in the employment of the same means in the treatment of bleeding from wounded arteries. The results of his investigations made in the Dorpat Surgical Clinic were published in Langenbeck's *Archiv* in 1869. Up to the present time he has cognizance of nineteen cases so treated—eleven being cases of his own, and the others occurring in the practice of other surgeons, most of them his own former pupils. In one of these no result was obtained, as the patient could not support the flexion, but in all the rest recovery took place. The wounds implicated the ulnar, the radial, the interosseous arteries, the palmar arch, the dorsalis pedis, the plantar, and the tibialis postica. The duration of the flexion varied much in different cases,—this being continued in one case to the eighteenth day without the patient suffering any considerable uneasiness. It is useful, when readjusting the apparatus, to change the angle by one or two degrees. The case reported by Von Burow, of gangrene of the hand following this procedure, says nothing against it, inasmuch as direct pressure was also employed. In none of Dr. Adelmann's cases has he met with even a trace of any such occurrence. In answer to a question whether this long continued flexion did not cause inconveniences by reason of the venous stasis it gave rise to, Dr. Adelmann replied that frequently there were all the signs of an obstructed circulation, but according to his experience after about twenty-four hours the compensatory circulation became established. To another question as to the duration of the flexion, he replied that we must in determining this proceed very cautiously, and not discontinue flexion until granulations have formed; yet he has been able to discontinue it after the third day without any hemorrhage occurring. He also observed that as physiology has not determined what are the changes which take place in the circulation in consequence of this angularization of the vessels, forced flexion can only at present be employed as an empirical remedy. He hopes that before long experimental investigations will be undertaken on animals, in order that we may be able to establish the practice of flexion in man upon a scientific basis.—*Med. Times and Gazette*, March 7, 1874.

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*Ligation of Left Subclavian Artery.*—A case of this is reported in *The Canada Lancet* (Oct. 1, 1873). The subject of it was a man æt. 35, who while drunk and lying with his arms across a rail had both crushed by a passing train, requiring amputation of the right arm in the middle-

third of the forearm, and the left at the shoulder-joint. Secondary hemorrhage occurred several times from the latter, and other measures having failed to entirely restrain the bleeding, Dr. CLARK ligated the subclavian. The patient made a favourable recovery.

—

*Tuberculosis of the Choroid.*—Dr. COUPLAND exhibited to the Pathological Society of London (*Lancet*, Feb. 28, 1874), a specimen of tuberculosis of the choroid from a child aged eight years, who died of tubercular meningitis three days after admission into Middlesex Hospital. On using the ophthalmoscope, the optic disks were seen to be normal, but there were seen scattered among the vessels a number of yellow flakes varying in size; they appeared to have no relation with the choroidal and retinal vessels. At the autopsy there was marked tubercular meningitis; the lungs and spleen were studded with miliary tubercles. The posterior two-thirds of the eyeballs were removed; the retina was intact, and a number of yellow spots were seen through it; on removing it, a number of small nodules, about twenty in each eye, were found. These were made up of round nucleated cells. The centre of the older nodules was breaking down. The tubercles were now seen to be round the vessels in the sheaths, and the case bore out Cohnheim's views on the anatomy of tubercle. Only one case of this kind had been reported six years ago by Mr. Soelberg Wells. Tubercle of the choroid is rare, but Cohnheim said it occurred in all cases of miliary tubercle.

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*Operations for Cataract.*—Dr. CARL SCHWAIGHOFER, Assistant Physician, Imperial General Hospital, Vienna, writes to the *Irish Hospital Gazette* (March 2), that "there were 363 cases of cataract (284 men, and 129 women) admitted into that hospital. In 207 of these, Graefe's linear extraction was performed, with the following results: Cured, 189; improved, 13; not cured 4; one died. A new operation, introduced by Weber, was at the same time tried in Prof. Arlt's *clinique*. The results attained by it, although good, are not quite so satisfactory as the above. They are as follows: Of 78 patients who underwent the operation, 68 were cured, 6 improved, 3 not cured, and 1 died of pneumonia. (Dr. Bergmeister informs me that the want of the proper instruments was a frequent cause of the non-success of Weber's operation.)

—

*Ovariotomy in Hospitals.*—The annual report of the Samaritan Hospital includes a proposition for preparing a separate house for ovariotomy cases, and it states the following grounds for that conclusion. "The operation called ovariotomy is acknowledged to be one of the most hazardous, critical, and trying the surgeon can have to encounter; while the patients are highly sensitive to the influence of any impurity in the air of the room, and immediately suffer from any want of scrupulous cleanliness. In the Samaritan Hospital, every such patient, after operation, is kept in a ward by herself till the result is known, and is then moved into a convalescent ward. General hospitals, as at present constructed, are certainly not fitted for such cases as these; the rate of mortality in them is seventy-six per cent. as compared with twenty-one per cent. in the Samaritan Hospital. This comparison is enough to warrant the adoption, as completely as possible, of the system of isolation contended for. The ovarian cases come chiefly under the care of the surgeon, who states, as his decided conviction, that a system of isolation more complete would be followed by still better results; and there are abundant reasons for thinking he is right." The report states that hitherto the hospital has been altogether free from hospital plagues, and it ascribes this immunity to good sanitary conditions. —*Brit. Med. Journ.*, March 7, 1874.

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*Blue Otorrhœa.*—Dr. E. TAUFAL draws the following conclusions:—

1. In otorrhœa, as in wounds, "blue pus" occurs, the dressing being coloured deep blue. 2. It has the reaction of litmus. 3. Quantities of *bacteria Termo* are found. 4. This blue suppuration can be artificially transferred to other indi-

viduals suffering with otorrhœa. 5. In all cases it disappeared spontaneously. 6. In one, after its disappearance, aspergillus was found in the meatus.—*Brit. and For. Med-Chir. Rev.*, Jan. 1874, from *Archiv. Ohrenheilk*, Bd. vi.

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*Monstrosity.*—Dr. Balle presented the other day to the *Faculté de Médecine*, a young girl aged fourteen, named Blanche Dumas, from Issondun, whose body, from the waist downwards, is double—the two parts acting independently of each other. The two legs she uses for walking belong each to a different trunk, while a third one is quite insensible to pain. Her health is good.—*Lancet*, March 7, 1874.

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*Chloral Hydrate as Preservative of Animal Matters.*—M. Personne, in a communication made to the Academy of Medicine (Feb. 10th, 1874), stated that some experiments which he had made on the action of chloral on albuminoid matters, had suggested to him that chloral might afford a means of preserving animal matter from decomposition. He exhibited a guinea pig which he had injected with a solution of hydrate of chloral in the latter part of October, 1873, and which had since shown no sign of alteration. A dog injected eight weeks before was equally well preserved.—*L'Union Médicale*, Feb. 12, 1874.

M. Hiron, interne of the Paris Hospitals, claims the merit of having first discovered this antiseptic property of chloral, the announcement of which he deposited in a sealed packet, with the Academy of Medicine, Jan. 21, 1873. The packet was by his request opened on the 17 Feb. 1874.—*L'Union Medicale*, Feb. 12 and 17, 1874.

Dr. B. W. Richardson, of London, however, made the discovery before either of the above claimants.

Dr. W. W. Keen, in a paper read before the Pathological Society of Philadelphia (*Phila. Med. Times*, March 21), relates a number of experiments which he had recently tried with chloral as an antiseptic for anatomical and pathological objects, and with very satisfactory results. He has also tried the chloral as a surgical application in some cases with good results, in others the reverse.

—

*The Danger of Badly-made and Old Catheters.*—This apparently trite matter is the subject of an important paper by M. Demarquay, from which we extract the following conclusions:—

"In many cases patients using catheters break off pieces in their bladders, and such accidents are dangerous and troublesome. The fracture is due, in some cases, to bad manufacture; in others to the age of the instrument. Nearly all Parisian instruments are liable to become brittle by age. Also special conditions of the patient render catheters liable to break. These conditions may be either in bladder or urethra. If a catheter has been left long in a bladder which contains pus, it *sometimes* will be found to have the point altered and brittle, but this is not invariable; nor does it seem to depend on the *quantity* of the pus in the urine. What causes the difference? Ammoniacal urine does so; but there are special conditions of inflammation which still require study in this point of view. Well-made instruments, and especially those made of vulcanized India-rubber, alter more slowly; but even they do alter in time. The changes are of two kinds. In some the varnish comes off, and the substance of which this instrument is made comes to pieces, and some layers of it may even fall into the bladder; or the roughened instrument may become coated with calcareous deposit, become rough, and cause much suffering on its removal.

"In other cases a catheter may, after some days, or even some hours only, in the bladder, be removed greatly altered; not so much in the part which had been in the bladder as in that which was in the urethra. I lately saw this occur after only twelve hours, in a patient who had stricture of the urethra. From his case I made out—1st, That the alteration in the instrument was proportioned to the amount of inflammation in the canal, and to the alkalinity of its secretions; and, 2d, that the better the instruments were made the less change took place. Great

differences exist in the manufacture of instruments." After a careful description of the methods of manufacturing good and bad instruments respectively, M. Demarquay points out that bad ones can be made more cheaply than good ones; and that, consequently, large numbers of dangerous instruments are made and exported. He suggests that instrument-makers should be inspected as well as druggists, and equally punished for selling dangerous instruments. In a word, in acid or neutral urine, even ordinary instruments are not liable to change, but in alkaline urine, and in proportion to the degree of its alkalinity, they do alter sooner or later, according to the quality.—*Ed. Med. Journ.*, Nov. 1873, from *La France Médicale*, No. 28, 1873.

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*Expert Testimony.*—We have had some remarkable, if not even criminal, specimens of expert evidence in this country, and it appears from a late case which has excited much professional indignation that they are not behind us in this respect in England. We extract the following statement from the *Brit. Med. Journ.* for Jan. 17, 1874. "Mrs. Gulliver was a woman aged 70, of spare habit, and enfeebled by poorness of diet. She had frequent fainting attacks; in her own written words—'I often go faint, and feel very queer.' She had been ill for two days prior to her death with a bilious attack; she had eaten heartily of stale pork-pie on Friday, and uncooked apples on the day before her death; and, having passed a very restless night, on the next day (Saturday) she complained of pain at the chest, with sickness, and vomited bile mixed with undigested apples. After the sickness was over, feeling exhausted, she wanted sleep. Her cough was troublesome, and she took freely of cough-lozenges, as to which she remarked that they always relieved her cough when troublesome, and gave her a good night's sleep. Her medical man, Mr. Walker of Crick, was sent for. He examined her heart, and found it diseased, and he sent her a little medicine (spirit of lavender and Hoffman's anodyne), and found her so feeble that he advised that her friends should be sent for. When her friends came, the sitting up and excitement brought on some vomiting again, which presently ceased, and did not recur. Mrs. Waters and Mrs. Watts sat up with her during the night, Mrs. Waters, as the evidence showed, never having been alone with her during the night. The doctor came early on Sunday morning, and gave a favourable report. She ate a good breakfast of tea and toast, and afterwards asked Mrs. Waters to sit and read to her; then asked for something out of a private drawer, which was found to be locked, and the key taken away by Mrs. Watts. She was excited, and then complained of feeling very faint. Mrs. Waters immediately saturated a handkerchief with eau de Cologne, and spread it about the bed. Mrs. Gulliver complained of the room being close; and the window was opened to let in fresh air. She revived, and drank a glass of sherry and ate some toast. A chapter from the Bible was being read by Mrs. Waters, and Mrs. Gulliver was repeating after her, when she suddenly stopped and fainted, and the servant was called, all the windows were thrown open to get a current of air, and the doctor was sent for. Some sherry was poured into her mouth, which she swallowed; but she did not afterwards speak; and when the doctor arrived, life was extinct.

"At the inquest, Mr. Walker, her medical attendant, testified that, when called to Mrs. Gulliver on Saturday, he found her suffering from sickness, and ascertained, by stethoscopic examination, disease of the heart. She answered questions rationally, but seemed drowsy, 'answering questions with her eyes half-open.' She died suddenly next day, and he gave a certificate expressing his belief that she died from valvular disease of the heart. At the *post-mortem* examination, he found all the organs healthy, except the heart, which was in a state of advanced fatty degeneration, with its walls much thinned, and one kidney, which contained a calculus. The vessels of the brain were not at all injected, and he found no other abnormal appearance. He added, in his evidence, that he found 'a high tempera-

ture of the body after death.' Dr. Buszard, of Northampton, who assisted at the *post-mortem* examination (after exhumation), corroborated Mr. Walker's statement of the anatomical appearances. Mr. J. D. Rodgers, lecturer on toxicology at the London Hospital, testified that he had examined the stomach and its contents, the heart, and the kidneys; that in the stomach and its contents only he found minute traces of morphia, which were not weighable, and certainly not sufficient to cause death. With the state of heart described, he would have expected Mrs. Gulliver to have had fainting attacks, and at any time a fatal syncope. When asked, however, whether he thought that Mrs. Guilliver's death arose from syncope, he said, 'No, certainly not syncope. Mr. Walker tells me that there was a high temperature after death; and that would negative the idea that she died from syncope. Further, I would state that, in consequence of this high temperature, I am of opinion that she died from some volatile noxious substance given to her immediately prior to death, but which I am unable to detect.' Upon that evidence, a verdict was found that Mrs. Gulliver died from poison, but by whom administered there was no evidence to show; and then a warrant was made out for the apprehension of Mrs. Waters, who had been one of the persons in attendance on Mrs. Gulliver during her last illness. Mrs. Waters, who had been in a private room adjoining, on hearing this intelligence, took poison; and a jury, subsequently impanelled on the body of this unhappy victim of an overwhelming blow, enough to overturn a well-balanced mind, returned a verdict of *felo de se*, necessitating her burial 'without clergy' within three hours, the service being read by her husband.

"Two more monstrous verdicts were, we believe, never delivered. The inference that an elevated temperature after death —which, by the bye, was only a vague statement—was evidence that death had been caused by some volatile poison is too absurd to require serious consideration."

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*Drink and Health.*—The article in *Good Words* (for Feb.), written by the Rev. Canon Kingsley, with the quaint title "The Tree of Knowledge," is one well deserving the attention of every medical man and sanitarian. In his characteristic way the writer casts aside the conventional opinions of the period, and the fruitless talk about the evils of drunkenness, and the much-bepraised remedy of total abstinence. He is ready to admit that drunkenness is on the increase in this island, because he finds its causes on the increase—"overwork of body and mind; circumstances which depress health; temptation to drink, and drink again, at every corner of the streets; and finally, money, and ever more money in the hands of uneducated people, who have not the desire, and too often not the means of spending it in any save the lowest pleasures." In these circumstances does he find the true causes of drunkenness, and draws the important general inference that "the craving for drink and narcotics, especially that engendered in our great cities, is not a disease, but a symptom of disease—of a far deeper disease than any which drunkenness can produce; namely, of the growing degeneracy of a population, striving in vain by stimulants and narcotics to fight against those slow poisons with which our greedy barbarism, miscalled civilization, has surrounded them from the cradle to the grave." The conditions of life of too many of our working classes are such as depress vitality, and are not counteracted in their effects by the good food and ample wages most of those classes can now command. These people in their mental and moral condition are unhappily in harmony with the wretchedness around them. They know no recreation beyond low animal pleasure; they drink for the brutalizing excitement to be got from their liquors, to drive away care, and often simply to drive away dulness. "But if the craving for stimulants and narcotics is a token of deficient vitality, then the deadliest foe of that craving and all its miserable results is surely the sanitary reformer; the man who preaches, and, as far as ignorance and vested interests will allow him, procures for the masses pure air, pure sunlight, pure water, pure dwelling-houses, pure food. Not merely every

fresh drinking-fountain, but every fresh public bath and washhouse, every fresh open space, every fresh growing tree, every fresh open window, every fresh flower in that window—each of these is so much, as the old Persians would have said, conquered for Ormuzd, the god of light and life, out of the dominion of Ahriman, the king of darkness and death; so much taken from the causes of drunkenness and disease, and added to the causes of sobriety and health." Much else breathing eloquence and truth may be read in the article from which we have quoted, and may be pondered upon advantageously by those who fain would coerce their fellow-men to become sober and religious, or work out their reformation by preaching and "spiritual exercises." —*Med. Times and Gazette*, March 7, 1874.

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*Recent Experiences of Spiritualism.*—Let our reader peruse the recent experiences of *Spiritualism* recorded in the *Fortnightly* and *New Quarterly Magazine*, for the narratives are well calculated to dispel all illusions about the mystery or power of the forces manifested in the phenomena of our modern spiritualism. The Socrates of the spirit-world, according to one medium, had a straight Grecian nose, among his other characteristics. As some doubt existed as to his identity, Viscount Amberley suggested that he should prove it by speaking in Greek, which had the effect of immediately stopping the mouth of that otherwise loquacious philosopher. Another medium, gifted with intuitive powers of discovering and healing maladies, found distinct evidences of a disease that the Viscount had never had, and of an operation he had never suffered. On the extraordinary credulity of the spiritualists and that of the mediums, so well pointed out by Viscount Amberley, we need not dwell. Mr. William Hipp has also recounted in the *Echo* his experience of a *séance*, with the celebrated Miss Cook as a medium. Among other manifestations the time arrived for the spirits to sprinkle the guests with water, a tumbler having been placed on the table for that purpose. The room was darkened and expectation was on tiptoe, but the sceptical Mr. Hipp grasped the tumbler, and in a few seconds clutched the hand that was dipped into it. As he had caught a spirit a light was procured, and a striking tableau presented itself. The spirit-hand had an arm of flesh, which formed part of Miss Cook's body. The censure and ignominy, he adds, that he brought on himself was only counterbalanced by the satisfaction he felt in having at last caught a spirit. Scientific men are invited to investigate the phenomena of spiritualism, and their refusal to do so is regarded as the result of a narrow-minded prejudice; but we agree with the editor of the *New Quarterly Magazine* when he says that the existence of delusion, and the manner of it being once explained, the subject ceases to possess any interest for educated and intelligent people. Discussion of such a topic affords neither instruction nor entertainment.

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*Obstetrical Society of London.*—This Society, at a large special meeting held on the 4th of March, decided, with but a single dissenting voice, against the admission of women to Fellowship in the Society.

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*Sir George Burrows, Bart.*—The honour of a baronetcy has been conferred on Dr. Burrows, President of the Royal College of Physicians, and Physician Extraordinary to the Queen.

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Obituary Record.—Died, at Brighton, on the 3d of March, Forbes Winslow, M.D., after a few days' illness, of bronchitis and pneumonia, in the 64th year of his age. Dr. W.'s name has been long associated with psychological medicine. He established the *Quarterly Journal of Psychological Medicine*, and conducted it for seventeen years, only giving it up when professional engagements became too pressing.

—— In London, March 2d, Neil Arnott, M.D., F.R.S., generally known through his admirable popular work on physics. He was also the inventor of "the water bed," and various other useful mechanical contrivances. For many years Dr. Arnott had given up medical practice in order to devote himself to scientific subjects.

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## CLINICS.

### CLINICAL LECTURES.

*A Clinical Lecture on Rötheln or German Measles.* Delivered at Middlesex Hospital. By ROBERT LIVEING, M.D., Physician to the Hospital.

GENTLEMEN: In April, 1870, Dr. Murchison directed attention in this theatre to two cases of German measles then under his care. Since that time until the present summer (1873) I am not aware that any similar cases have been admitted into our hospital; indeed, the malady is generally of so mild a character that it is not commonly seen in our wards. It is therefore all the more important that you should turn your attention to it whenever occasion offers; for ignorance of its peculiarities may hereafter involve you in troublesome errors of diagnosis in the practice of your profession.

The disease we are speaking of was first described by German writers more than half a century ago, under the name of "rubeola," by which name it is still known in Germany. Unfortunately the same name has been applied in this country to common measles, or morbilli, so that we are obliged to introduce a new name, such as "German measles," "rötheln," or "hybrid measles," or "hybrid scarlatina." The two latter names are most objectionable, inasmuch as they give colour to the erroneous notion that the disease is a combination of measles with scarlatina.

Jane B———, aged twenty-seven, admitted June 10th, 1873, housemaid. This case was placed under my care by Dr.

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Harling, who had recognized it as one of German measles. When about eight years old the patient had a sharp attack of measles. On Sunday morning, the 8th of June, at 7 A. M., she had a feeling of nausea, which lasted during the morning, but passed off after dinner. On Monday morning, the 9th, about seven o'clock, the same feeling returned, accompanied with headache. At breakfast she found that her throat was sore on swallowing, and also noticed lumbar pains. At about 2 P. M. she saw that her face was red and a little swollen, then that her neck, back, and chest were flushed in a similar manner. She went to a doctor the same evening, who stated that in his opinion her complaint was measles. On the 10th, she noticed that her legs were affected, being red all over. She felt feverish.

On admission, the whole body of the patient was covered with small patches of a red papular eruption, most marked on the back, where it was more or less confluent. There was slight sore-throat, and the fauces were red. The conjunctivæ were somewhat suffused; the tongue was marked by the teeth, and of a brownish colour in the centre. The physical signs of the chest were fairly good; the bowels rather confined. The urine contained no albumen.

*June* 12. The rash is beginning to fade, and is slight on the hands and feet.

13*th*. The tonsils are rather swollen, the left more than the right. There is a slight trace of albumen in the urine.

14*th*. The left tonsil is ragged and painful; the vessel can be distinctly seen running over the posterior surface of the pharynx, which has scattered over it patches of a whitish-yellow colour. The rash is fading, but has not quite disappeared, and the temperature is normal. The bowels open freely.

16*th*. The urine is acid, 1032, and loaded with urates; no albumen.

17*th*. The throat is rather better, and there is no pain, and no rash to be seen.

25*th*. The patient was discharged convalescent. The eruption lasted seven days, but never became thoroughly confluent.

The patient was under observation for some weeks after her discharge; there was a very slight branny desquamation of cuticle.

[Four other cases are related by Dr. Liveing, the details of which it is unnecessary to give here.]

*Remarks.*—The following points are especially worthy of note:—

1. The premonitory fever in German measles is generally mild, and resembles in many respects, though not in duration, that of common measles. There is more or less pain in the limbs, slight shivering, sore-throat, and often, though by no means always, coryza, redness of the conjunctivæ, and sneezing. All these symptoms were present in some of the cases I have had under my care. The characteristic features, however, of the premonitory fever, as contrasted with that of measles, is its *duration*, which is seldom much more than twenty-four hours, whereas in measles, it is from three to four days—that is, the eruption of the latter disease appears on the fourth or fifth day. Dr. Murchison remarks on this point, that "most authors fix the duration of this stage at about three days, the eruption being said to appear on the third or fourth day. In my experience, its duration, as in the cases you have seen in the wards, is much shorter, the rash appearing on the second day, or even within the first twenty-four hours." Dr. Murchison's experience is entirely borne out in this respect by my own, and that of many other observers. Indeed, I consider the short duration of the febrile attack before the eruption appears as one of the most constant and distinctive features in which this fever differs from ordinary measles.

2. The character of the eruption when it first appears is almost always described as "measly"—that is, in small reddish patches. In the first instance the rash consists of small rounded collections of minute red papules, which after a time coalesce and form larger irregular patches, just as in measles, but with apparently less tendency to become of a horse-shoe or crescentic shape. After a time the patches may all unite, and then the skin becomes to the naked eye of a uniform red colour, closely resembling that in scarlet fever.

This coalescence of patches was complete in two of the cases recently under my care in this hospital. In the other cases the confluence was only partial, the eruption retaining some of its patchy character until it finally faded away. The rash is generally of a rather brighter colour than is met with in typical measles. "The eruption," says Dr. Murchison, "is copious in direct ratio to the severity of the general symptoms. It lasts longer, as a rule, than the rash of either measles or scarlet fever—from four to ten days. Its disappearance is followed by a desquamation of branny scales." With regard to the desquamation, I would remark that it is generally such a characteristic feature as in scarlet fever. Very mild cases of the latter disease often desquamate freely. Mild cases of German measles, on the other hand, desquamate but little, as in the cases before us, where it was but slight. The protracted duration of the eruption is certainly one of the characteristics of the malady, though no doubt a more or less variable one, and of little or no value as a means of early diagnosis. In the cases under my care in the hospital the eruption lasted from five to seven days—a longer time than is usual either in measles or scarlet fever.

3. Amongst the most constant symptoms of this fever is the persistent, though not generally severe, sore-throat. The tonsils are red and swollen, and remain in that state usually for some days after the rash has faded; indeed, the sore-throat is often the last symptom to disappear. This soreness about the fauces is by no means of the same severe character as that met with in scarlet fever, and very rarely leads to ulceration.

4. The presence of albuminuria is of not unfrequent occurrence, and it was present for a short time in two of the examples under discussion. It does not always, however, pass away rapidly, as it did in these cases; it may become chronic, or even lead in some rare instances to acute dropsy. This, in fact, constitutes the chief and almost the only grave feature of the disease, but, as it rarely occurs, a favourable prognosis may be given.

5. The disease propagates itself, and never leads to the production of either scarlet fever or measles in others. The seed, as a gardener would say, comes up true. This is a fact of great importance, and almost conclusive against its being either a mild form of morbilli or scarlatina, or even a combination of the two.

6. German measles affords no protection from either of its allied diseases; nor does scarlet fever or measles protect in the slightest degree from attacks of rötheln. This fact, if admitted—and it is undoubtedly true—is the strongest possible evidence that the disease is distinct from all others, however its superficial appearance may lead us to believe that it is some modified form, or so-called hybrid, of scarlatina and morbilli. All my patients, with one exception, had previously had measles. My own opinion is, that rötheln is more distinctly epidemic, at least in this country, even than ordinary measles, and certainly more so than scarlatina; and, further, that it is probably far less contagious than either of those diseases, though on this point I should be very unwilling to dogmatize. Several convalescent children were in constant communication with the cases in my wards, but not one of these children contracted the malady. Moreover, several cases that I have had under my care in private practice have failed to communicate the disease to others.

In conclusion, I would remark that German measles is not yet fully recognized by the profession in this country; little or no account is given of it in our ordinary text-books on medicine, and its name does not find a place in the "nomenclature of diseases" drawn up by a committee of the Royal College of Physicians. Under these circumstances, it is not surprising that errors of diagnosis should sometimes bring discredit on our profession. For example, a medical man is called in to a case of German measles in its early eruptive form; he is not particular to inquire about the symptoms or the duration of the premonitory fever, and he at once pronounces it *measles*. Perhaps this would be of little importance if the case remained under his care, but unfortunately he is sent for to the country, and in

the mean time the character of the rash of his patient has changed to a uniform red eruption, and is pronounced by some other medical man to be *mild scarlatina*. In the course of ten days, probably, the patient is well, and it then is evident that the case is one neither of measles nor of scarlatina, but of rötheln. It is in order that you may be on your guard against similar mistakes that I have to-day directed your attention to this subject.—*Lancet*, March 14, 1874.

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*Abstract of a Clinical Lecture on Transfusion in Anæmia.*—Professor Behier has published an important clinical lecture which he delivered at the Hôtel-Dieu on a successful case of transfusion in anæmia, in which he enters into the general question at considerable length. A woman, twenty-one years of age, was brought to the hospital on January 24 in a fainting condition, having been the subject of very profuse metrorrhagia during the twelve preceding days. Notwithstanding all attempts at its permanent arrest by means of ice, ergot, plugging, etc., the flow of blood continued, so that at length she became so reduced by the 29th that death seemed imminent. Exploration failed to reveal any cause for the hemorrhage, which was therefore attributed to prolonged lactation of an infant sixteen months old, combined with her laborious mode of life. However this may be, she was dying of anæmia, and incoercible vomiting preventing the administration of food or stimuli, it was resolved to resort to transfusion. M. Behier employed Moncoq's apparatus as modified by Matthieu. Believing the introduction of a little air into the vein selected is of no great consequence, provided the vein be one of those of the extremities, he strongly objects to the employment of defibrinated blood, which he regards as a practice quite at variance with physiological teaching. For those who doubt their dexterity in introducing the canula, he recommends that the vein should be previously opened by a lancet exactly as for venesection, the opening not being a large one, but only sufficient to admit the fine orifice of the canula. Whatever the apparatus employed, it is a rule of the highest importance that the blood should be introduced very slowly by a continued and regular movement, unaccompanied by any jerking or suddenness. If this slow introduction be not well observed, we may have, as indicated by Brown-Séquard, death by syncope or convulsions accompanied by vomiting. This syncope would appear to be correctly attributed to the too great distension of the right ventricle, the walls of which are paralyzed. There is also another class of accidents which may follow the too sudden or too copious introduction of blood. The patient falls into a sort of inertia, the face becoming pale and puffed, while the eyelids are swollen and assume a slightly violaceous colour, the torpor is well nigh complete, and the patient dies, not suddenly, but at the end of some hours. The explanation of this occurrence is involved in some obscurity, but it is of the highest importance to prevent so redoubtable an accident. A sign of its imminence to which M. Behier attaches great importance is the occurrence of a slightly dry cough. Wherever this is observed the injection should be arrested, for it is the first indication of a commencing pulmonary congestion, and the slightest degree of the accidents just mentioned. The primary precaution to be taken is to inject very slowly—not so slowly, however, as to give time for the blood to coagulate. With Moncoq's apparatus, which at each turn of the rack injects five grammes of blood, only half a minute is required for the blood to pass into the vein; and when slowness is counselled, it is so only relatively to the haste and suddenness too often employed. A guide in the matter is found in the normal course of the venous blood, which is what we should seek to imitate, keeping, as regards the impulse imparted, somewhat within physiological rapidity. It is also of importance not to inject too large quantities of blood at a time. In this patient about eighty grammes were injected. This was done slowly, and yet in her there was almost a threatening of the accidents that have been referred to.

The injection, which occupied about three minutes, was made at ten o'clock, and in about an hour she was able to drink without vomiting. The pulse continued miserable, and it was not until one o'clock that very decided improvements were observed. By four she was able to take food, and had lost a cephalalgia that had been very distressing before the operation. We need not pursue the details further, it sufficing to say that the patient is now well.

The apparatus of M. Malassez for the enumeration of the red globules was employed in this case. On the 29th, prior to the transfusion, there were found to be 850,000 red globules per cubic millimetre, while four hours after the operation there were 1,110,000. In eight hours after the transfusion 1,143,000 were counted. On February 13 they reached 1,850,000, and on March 4, 2,029,500. Thus, it is evident that life once revived by the injection of the tonic blood, the patient was henceforth enabled to produce new globules. It is to be observed, however, that in her there was no affection of the stomach, which is a favourable circumstance, the absence of which in other cases may explain their failure, the stomach in them not being able to continue the reparative action commenced by the transfusion. This is a point always to be borne in mind in deciding upon the propriety of undertaking transfusion.

This case which I have now detailed to you is instructive in many respects. On the one hand, it exhibits to you the marvellous efficacy of transfusion, which in this instance most certainly has preserved the life of the patient. Another lesson which is distinctly derivable from our case is the efficacy of relatively small quantities of transfused blood. Eighty grammes (twenty drachms) of blood have sufficed to save this woman. As a general rule, then, avoid injecting too large a proportion, for this is the best means of warding off pulmonary accidents and syncope. It is far better to return again to the charge, and practise successive transfusions, than to risk injecting too much at once. Again, it does not seem to me to be doubtful that non-defibrinated blood, inasmuch as it is intact and enjoys all its properties, is more apt to act in moderate quantities than blood which has been despoiled of a portion of its principles, and altered by whipping.—*Med. Times and Gaz.*, March 21, 1874, from *Révue Scientifique*, March 7, 1874.

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### HOSPITAL NOTES AND GLEANINGS.

*Multilocular Cyst of the Ovary; Ovariotomy; Death.* Under the care of Mr. Lawson Tait at the Birmingham and Middlesex Hospital for Women.

The following case, in the opinion of Mr. Lawson Tait, shows the uselessness of a retro-uterine drainage-tube after ovariotomy, as advocated by Dr. Marion Sims, and illustrates the comparative effect of methylene ether and sulphuric ether when used as anæsthetics.

H. L——, aged thirty-four, admitted January 2, 1874, with large multilocular ovarian tumour, which had been several times tapped, and one of the cysts of which had suppurated and burst about two inches above the umbilicus. The patient was very anæmic, had a weak heart and a considerable amount of albuminuria, so that it was thought very doubtful whether she should be submitted to ovariotomy, more especially as there was a strong probability of the existence of dense adhesions. Under the administration of iron and ammonia the albuminuria diminished very much in amount, and on January 7th the patient was placed under the influence of methylene ether in order to admit of a thorough examination of the pelvis and of the extent of the suppurating cavity. Before the anæsthetic was given, the pulse, though weak, could easily be felt, but as she gradually got under the influence of the ether the pulse became weaker and weaker until it could be recognized with difficulty. When the anæsthetic was stopped the pulse became gradually more perceptible, and soon resumed its original force. This process was repeated on a second trial of the ether without the occurrence of anæsthesia sufficiently complete to allow of the desired examination, and, as

it became evidently desirable to use some other anæsthetic, sulphuric ether (anhydrous) was substituted. Complete anæsthesia was obtained by this agent, with considerable difficulty, but without the slightest diminution of the pulse-force during its administration.

The examination showed that the pelvis was free from adhesions, and it was therefore determined to give the patient the chance of the operation, as she herself earnestly desired it, and had come from Yorkshire especially to have it done.

On Jan. 10th she was again placed under the influence of anhydrous sulphuric ether to the extent of complete anæsthesia without any perceptible alteration of the pulse-force. The ether, as usual, took a long time, and a large quantity was required to produce the desired effect, and during the operation the supply ran short. In the few minutes' interval necessary for renewing the supply the methylene ether was used to sustain the anæsthesia; but very little of it had been used before the administrator, Mr. Wright Wilson, noticed that the pulse was failing, precisely as it had done on the previous occasion. On the re-employment of the sulphuric ether it rapidly regained its volume, and the operation, a very tedious one, was completed without any further anxiety on account of the patient's pulse.

Here, in an unwished-for and unexpected manner, a comparative experiment was made, and verified by repetition, of the different effects of the two anæsthetics, and the result can be stated with a scientific accuracy rarely attainable in clinical therapeutics, that sulphuric ether is a much safer anæsthetic than methylene ether. It was perfectly evident that the methylene ether, on both occasions of its trial, had a direct and immediate depressant action on the heart—an action which would probably have been fatal if continued; and the second experiment showed distinctly that sulphuric ether not only had no such depressant action, but, on the contrary, acted immediately as a stimulant.

The tumour proved to be a large multilocular dermoid cyst, densely adherent, as had been previously diagnosed. So dense were the adhesions that several plates of calcareous matter, one two inches in length by one in breadth, had been formed in the peritoneum. The adhesions were very extensive, affecting the whole of the anterior and lateral walls from two inches below the umbilicus upwards. There were no adhesion in the pelvis, none to the viscera, and only one of recent date and of small extent to the omentum. The hemorrhage from the adhesions was tolerably profuse, but only one point required to be tied. It seemed to be a suitable case, if any such could be found, for the insertion of a drainage-tube through the retro-uterine cul de sac; and, with the concurrence of his colleagues, Dr. Savage and Mr. Ross Jordan, Mr. Tait passed a double loop of large-sized wire drainage-tube through the roof of the vagina.

A few hours after the operation a faintly reddish-coloured serum began to pass from the wound about its middle, and continued to do so up to the patient's death; probably several pints in all so passed. Not a drop, however, came by the tube until the body was moved after death. At the post-mortem examination it was evident that the tube was occluded by the pressure of the intestines, for as soon as they were lifted out of the pelvis a large quantity of fluid flowed rapidly through the tube.

The patient died of shock; for there had been no hemorrhage, nor were there any signs of peritonitis.

Of five other cases of death after ovariotomy in which Mr. Tait has obtained or seen post-mortem examinations, and in which the cause of death was the effusion of purulent or other fluid into the peritoneum, in not one could a drainage-tube have been of the slightest use; and the possibility of benefit arising from the insertion of one seems to be very remote, while the probability of its doing harm is very considerable.—*Lancet*, February 21, 1874.

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*Two Cases of Penetrating Wound of the Abdomen, treated at the Hôpital St. Louis, Paris.*

Case 1. The wound was seated in the left hypochondrium, and was caused by a

gouge. Hemorrhage occurred, and the epiploon came through. When admitted into the hospital, the epiploon formed a tumour of the size of a nut; it was strangulated by the lips of the wound, but was not very painful. Ice was ordered to be constantly applied to the abdomen, so as to ward off consecutive inflammation, and occlusion was effected by means of goldbeaters'-skin and collodion. After three days the use of ice was discontinued. No reaction occurred; obstinate constipation was observed. Three successive doses of saline purgatives were required to bring on a *débâcle*, or breaking up of fecal matter. Eight days after, the goldbeaters'-skin was removed, and lint was simply applied. The tumour had diminished, and was painless; it was very vascular, and fleshy granulations of an excellent character were noticed on the epiploon. On the 29th October (fourteen days after admission) the patient left the wards. There existed a tumour of the size of a small cherry; the surrounding part of the pedicle was hardened, and a kind of puffiness extending into the abdomen was to be noticed.

Case 2. The above case may be compared with another one admitted some time previously into the wards. The patient had received a cut with a knife slightly below the epigastrium on the mesial line. The protruded epiploon formed a tumour of the size of the fist. The surgical treatment was the same. Healing was left to nature, and all went on safely and nicely. At the end of two months the tumour had diminished to the size of a nut, and offered the same characters as the one described. The process of disappearance of the tumour is effected by means of suppuration and of decreasing size; it returns gradually into the abdomen.—*Lancet*, March 14, 1874.

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*Excision of the Knee-joint.*—Dr. E. A. Rawson reports (*Irish Hospital Gaz.*, March 16) the following interesting case of this. The subject of it was a strong, healthy looking fellow, æt. 28, admitted into Carlow County Infirmary with his right knee anchylosed, which prevented his doing any work. Several years before he had had an attack of inflammation in the joint, and the leg had been allowed to remain bent The anchylosis was very firm, and no amount of force could move the knee in any way whatsoever. He had no pain, and was in perfect health. On the 28th of Sept. 1869, "having been put under the influence of chloroform, the patient was placed on the table, with his legs hanging over its end. Standing on his right—the affected side—I made a single semilunar incision from the internal condyle of femur to the external, below the patella, opening into the joint, with the one sweep of the knife. I now grasped the ankle, and forcibly flexed the leg on the thigh; the anchylosis gave way with a loud crash. But few traces of the articular cartilage remained; all the ligaments were, however, entire. After dissecting the soft parts from the bones, I removed about two inches of the femur, and a quarter of an inch of the tibia, with Butcher's saw. There was scarcely any bleeding. One small vessel was secured by acupressure. I then attempted to straighten the leg, but could not do so, as enough had not been taken off the tibia, and the contraction of the hamstring muscles also prevented me. Accordingly, I removed another quarter of an inch, straightened the leg with ease, and closed the wound with wire sutures, dressing it with carbolic acid and oil, equal parts. The hemorrhage was of the slightest nature. The limb was bandaged, and placed in a box splint, with hinge sides, and the patient put to bed. He rallied well from the chloroform, and expressed himself as feeling very comfortable. I stayed with him for some time after the operation, and all went on well. About three hours after I left him, I received a message that he was bleeding. I went to him at once, and found him deluged with blood. It had soaked through the bed, and made a pool on the floor. He was pale as a sheet, and sighing. I opened the wound, turned out large coagula, and flexed the leg on the thigh. There was no arterial hemorrhage, but a general oozing poured from the cut ends of the bones. I soaked them with perchloride of iron; useless. Aluminate of iron checked the hemorrhage for the mo-

ment, but it soon poured out afresh. I then freely applied skewers, at a white heat, but they seemed to make the blood come more rapidly. The ether spray now checked the hemorrhage as long as I kept it applied, but the moment I stopped, it commenced again. The patient was swallowing quantities of whiskey and beef-tea, etc., but he began to faint; his eyes became glassy and fixed. I placed a sponge between the bones, and shutting them up on it, closed the wound. There was very little more blood for him to lose, but at any rate no more came. To my astonishment he rallied, was much stronger next day, and took a large quantity of nourishment. On the third day I removed the sponge with difficulty, as the granulation had grown into it. I made a mental note to use a pad of lint in any future similar case. The wound healed, and the bones united rapidly without any drawback. The patient grew fat, and stronger than ever, and in two months was walking about with crutches, which he soon discarded for a walking stick. This he shortly after threw aside, and could beat any ordinary man at walking. Discharged from Hospital, December 20th, 1869. I heard that he was shown in the theatre of the Meath Hospital about two years ago; and I met him since in the Athy Poorhouse, a stout, able-bodied pauper, with a perfectly straight, stiff leg, and a semilunar scar at the knee, which looked very like a normal knee-joint, as I had left the patella. The shortening was not observable, and he did not wear a high-heeled boot, attributable, no doubt, to the pelvis accommodating itself to the shortened leg."

Dr. R. reports also another similar case in which the ends of the bones also bled very freely, and nothing availed to stop the hemorrhage but the pressure of lint with the fingers. "Aluminated iron, effective in the former case, was nearly quite useless in this. However, soaking a pad of lint in it, I placed it between the ends of the bones, shut them up together, and closed the wound; pads of lint were placed all round, and firmly bandaged down. There was no secondary hemorrhage, and he rallied well. On the third morning I opened the dressings, and extracted the pad of lint from between the bones. The wound rapidly healed. A few large granulations were kept down with sulphate of copper. There was very little suppuration, and the pus came away at the angles. The limb was kept in a long box splint, with hinges at the sides. It was dressed first with carbolic acid and oil, equal parts; then with bluestone wash; then, in consequence of some inflammatory symptoms, poulticed for about ten days." The patient recovered, and was able to walk without a stick. As in the first case, the patella was not removed.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Diphtheria.*—At a late meeting of the New York Pathological Society, Dr. J. Lewis Smith presented a specimen of diphtheria, with the following history; T., aged three years, died after a sickness of about one week from diphtheria, which supervened upon measles. During the last four or five days of the disease the symptoms, namely, stridulous inspiration, depression of the sternum during inspiration, and lividity of the lips and tips of fingers, indicated extreme laryngo-tracheal obstruction. The fauces, which were inspected each day, were constantly swollen and injected, but without a pseudo-membrane. Five days before death the pulse was 164, respiration 28 per minute, and temperature 101½°; two days before death the pulse was 160, respiration 28, and temperature 104°.

The post-mortem examination embraced only the larynx, trachea, and commencement of the bronchi. A continuous pseudo-membrane extended from the tip of the epiglottis downward over the mucous membrane as far as it could be traced in the dissection. It was thicker and firmer below than above, so that it probably extended into the smaller divisions of the bronchial tree. It was somewhat pultaceous on the under surface of the epiglottis and in the larynx, but it could not be readily separated from the mucous membrane; while in the trachea it was readily detached in a thick and

firm layer. The mucous surface underneath presented a deep-red colour, and was considerably thickened by hyperæmia and infiltration.

It seems evident that the disease of which this child died was diphtheria, and not true croup, from the fact that the former was epidemic in the institution at the time, three children having diphtheritic inflammation of the eyelids in the same ward in which this patient was treated.

During an epidemic of diphtheria the specific inflammation is apt to attack those surfaces which are already inflamed or irritated, and in many patients it affects only such. Therefore if it attack a patient with scarlet fever, its seat is the fauces, and if, as in the present instance, one with measles, in which there is general inflammation of the air-passage, it ordinarily involves not only the fauces, but also the surface of the larynx, trachea, and bronchial tubes, being, therefore, from the extent and thickness of the pseudo-membrane, ordinarily fatal. The three children with diphtheritic conjunctivitis, alluded to above, were previously under treatment for inflammation of the eyelids

It is important, both as regards prognosis and treatment, to determine in cases like the above, in which there is obstructed respiration but no pseudo-membrane on parts which are visible, whether the laryngo-tracheitis is catarrhal, with an unusual degreee of infiltration, or pseudo-membranous. From my observation of these cases I do not doubt, if the dyspnœa do not begin to abate by the second or third day under appropriate treatment, that we are contending with a pseudo-membrane.

This patient was treated with quinia, iron, and alcoholic stimulants internally. The quinia was administered in moderate doses; but in severe diphtheria and scarlet fever large or frequent doses of this agent are tolerated, and are sometimes apparently useful. When I entered on duty in the Asylum in the same epidemic, one of my colleagues was treating a patient of three and a half years, having severe scarlet fever and diphtheria, with two grains of quinia administered hourly, and though forty-eight grains had been given in twenty-four hours, the pulse was 156 per minute, the temperature, 103$\frac{3}{4}$°, showing that there was not such reduction of pulse and temperature as ordinarily attends the employment of large doses of this agent. The patient recovered, the quantity of quinia administered daily being, however, reduced to twelve grains.

The local treatment in the case which I have related consisted in the application to the fauces, every three hours, of the following, which has given me better satisfaction than any other medicine for local treatment which I have employed: ℞.—Acidi carbolici, gtt. v; Liq. ferri subsulphat. ℥ij; Glycerinæ, ℥j.—M.

The brush was employed in preference to the probang, as it is less painful, and where there is a pseudo-membrane does not produce hemorrhage by its detachment.

The small room in which the child was treated was also filled, as far as possible, with steam. As steam or water softens the epidermis, so I believe that it softens and aids in the removal of the pseudo-membrane, which is mainly epithelial, more effectually than any other local measure. In each of the shallow pans from which the steam was generated, a small lump of quicklime was placed, so that the steam was charged with particles of lime, which were quite perceptible in the breath. If much lime be added, the water becomes too thick or syrupy, so as to diminish the evaporation, and therefore render the quantity of steam insufficient. The spray of lime-water, whatever may be its solvent effect, certainly renders the respiration in a close and hot room more tolerable, perhaps from its rapid absorption of carbonic acid.—*Medical Record*, April 1, 1874.

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*Treatment of Pertussis.*—At a recent meeting of the New York Pathological Society, Dr. J. Lewis Smith stated that his own experience with the belladonna and quinia, now in a considerable number of cases, without, however, any exact statistics of their effects, incline him still

to prefer belladonna in ordinary cases, given twice daily in doses sufficiently large to produce its physiological effects. An abatement in the severity of the cough may be confidently expected when the belladonna has been employed a few days. Quinia is useful, in addition to external irritation, when there is febrile movement with accelerated respiration, due to bronchitis or broncho-pneumonia. If cerebral symptoms arise, bromide of potassium Dr. Smith has found more useful than any other remedy, administered alone or with iodide of potassium.—*Medical Record*, April 1, 1874.

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*Removal of Five Inches of Sciatic Nerve.*—The patient was a female, who had been admitted to Bellevue Hospital on account of a tumour which was situated in the posterior portion of the left thigh, which was then giving her considerable inconvenience, although it had been first noticed more than a year.

It was decided to remove the tumour. When cut down upon, it was found to be intimately connected with the sciatic nerve, and to such an extent as to preclude all possibility of its removal, without completely removing a large portion of the nerve. A halt was made, and a counsel held with regard to the proper method of procedure. It was decided to remove as much of the nerve as might be necessary to permit the removal of the tumour, and await the result. Accordingly, about five inches of the nerve were removed, the wound dressed, the patient placed in bed, and the result of the operation anxiously awaited. The patient was discharged from the hospital within three weeks, with but slight impairment of motion and sensation.—*Med. Record*, March 2, 1874.

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*Local Action of Bichromate of Potash.*—Dr. Green reported to the Boston Society for Medical Observation (*Bost. Med. and Surg. Journ.*, Jan. 15, 1874) three cases lately seen by him, which exhibited the local effect of bichromate of potash on the nose. They occurred in workmen of a large chemical manufactory, who were exposed to the dust of the salt, which, by lodging on the mucous membrane of the nose, caused ulceration. In one of the cases, the entire cartilaginous septum had been destroyed, and the whole nasal mucous membrane was in a state of purulent inflammation; in another, there was a large and deep ulceration on the septum, without perforation; while, in the third, the whole membrane of the septum was dotted with minute ulcerations. In the first case, the disease had been mistaken for syphilis. The removal of the men from their work, strict cleansing of the part with a syringe, and the application of mild stimulating lotions, checked the ulcerations immediately, and soon restored the membrane to a healthy condition. By the use of cotton-wool respirators, as suggested by Tyndall, the men afterwards resumed their work, and have continued free from trouble.

Almost every one in the factory had been more or less affected by the dust of the salt; some with ulcers on the hands and body, others with nausea, and almost all with more or less purulent nasal catarrh. The severity of the symptoms was generally proportional to the amount of the dust to which the persons had been exposed.

—

*Cerebral Symptoms produced by the Use of White Lead as a Cosmetic.*—Dr. James H. Hutchinson reports (*Phila. Med. Times*, Jan. 17, 1874) two cases of cerebral symptoms produced by use of white lead as a cosmetic, and a third in which only the more usual symptoms of lead poisoning were observed.

—

*American Medical Association.*—The Twenty-fifth Annual Session will be held in the city of Detroit, Mich., on Tuesday, June 2, 1874, at 11 A. M.

The following amendment among others to the Plan of Organization is to be acted upon:—

For the second paragraph of Art. II. substitute the following:—

"The delegates shall receive their appointment from permanently organized State Medical Societies, and such County and District Medical Societies as are recognized by representation in their re-

spective State Societies, and from the Medical Department of the Army and Navy of the United States."

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*Medical College of Ohio.*—Several changes are announced in the Faculty of this school. Dr. James Graham, Professor of Practice of Medicine, has resigned, and been appointed Emeritus Professor; Professor R. Bartholow has been transferred from the chair of Materia Medica to that rendered vacant by the resignation of Dr. Graham; Professor Samuel Nichols has been transferred to the chair of Materia Medica; and Dr. Clark, formerly Demonstrator of Chemistry, has been appointed Professor of that branch.

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*Jefferson Medical College.*—At a meeting of the trustees of this institution held on 7th of April, WILLIAM H. PANCOAST, M.D., was elected to succeed his father, Prof. Joseph Pancoast, in the Professorship of Anatomy.

—

*Philadelphia College of Pharmacy.*—At the commencement, held on the 12th of March, the degree of Graduate in Pharmacy was conferred on 81 candidates.

Mr. Joseph P. Remington has been elected Professor of Theory and Practice of Pharmacy in this College of Pharmacy, in place of the late William Procter, Jr.

[1] By a misprint given as 181 in our preceding number.

*Missouri Clinical Record.*—This is the title of a new monthly medical journal, the first number of which appeared on the 1st of April of the present year. It is edited by Dr. Hardaway, Clinical Lecturer on the Diseases of the Skin, Missouri Medical College. The number before us has a very neat appearance, and is well supplied with useful matter. We welcome our new contemporary to our exchange list, and wish it success.

—

*The late Prof. Henry Miller, M.D.*—At a stated meeting of the College of Physicians of Philadelphia, held April 1, 1874, the following preamble and resolutions were adopted:—

"*Whereas*, The College of Physicians of Philadelphia have heard with profound regret of the death of Prof. Henry Miller, M.D., of Louisville, Kentucky, an Associate of this College; and whereas, it is meet and proper, when a great and good man dies, his surviving friends should record their opinion and feeling of his worth; therefore, be it

"*Resolved*, That in the death of Dr. Henry Miller, for nearly a third of a century Professor of Midwifery, first in the University of Louisville, and afterwards in the Louisville Medical College, medical science has lost one of its most zealous votaries, obstetric medicine one of its most instructive and lucid expounders, and American authorship one of its most able and distinguished writers.

"*Resolved*, That a minute of these proceedings be recorded upon the books of this College, as a mark of our appreciation of our deceased associate; that a notice of them be published in the medical journals of this city, and also that the Secretary be instructed to send a copy of them to the family of the late Prof. Miller, with the assurance of our heartfelt sympathy in their bereavement."

## FOREIGN INTELLIGENCE.

*Syphilis and Mercury.*—There are few remedies which, through a couple of centuries have by turns been in disgrace and in great favour. Among these mercury holds the foremost rank, and so late

as the 8th inst., at the Hunterian Society, Mr. Jonathan Hutchinson thought that additional testimony was needed to strengthen the faith of those who believe in the efficacy of this drug in lues venerea. The meeting was numerously attended, several of the London syphilographers being present, and much interest was evinced in Mr. Hutchinson's paper, in which he, by facts and arguments, strove to prove that full reliance should be placed on mercury in the different stages of syphilis. The non-mercurialists did not muster very strong, only one representative of the sceptics being present, who, though he tried to make good a few points, did not succeed in carrying the audience with him. Mr. Hutchinson's supporters were more numerous, and plainly stated their confidence in the use of mercury. If this meeting may be taken as a tolerable criterion of the state of the question in London, the mercurial treatment of syphilis is decidedly in favour. But in controversies of this kind the *audi alteram partem* should be ever borne in mind; and it remains to be seen whether an anti-mercurialist champion will shortly bring the subject before a medical society, and throw the weight of certain facts and arguments, which have long been before the profession, into the scale. The latest book published on the cure of syphilis without the aid of mercury is by M. Desprès, of Paris. This author considers syphilis as a pyæmic affection, and treats it on hygienic and antiseptic principles. M. Desprès was for a series of years surgeon to the female Lock Hospital of Paris, and therefore deserves to be heard.—*Lancet*, Jan. 17, 1874.

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*Uses of Chloral in Cancer.*—The uses of chloral in cancer were discussed at the last sitting of the Société Thérapeutique. Its efficacy in cancer was pointed out by Dr. C. Paul, who had used it in the shape of suppositories containing fifteen grains of chloral. Introduced into the vagina, they had procured sound sleep during a whole night in cases where considerable doses of morphia had no anodyne effect, while the nature of the secretions, and especially their fetor, were favourably modified. Dr. Martineau mentioned a case of recurring cancer of the breast which had almost reached the thoracic walls and the lung. Pledgets of lint steeped in a solution of chloral were introduced. Three days after the surface had assumed a healthy hue, and was granulating kindly; the fetor had vanished and the hemorrhage stopped. Cancer of the uterus had likewise improved, so far as the pain and fetor were concerned, under similar treatment.—*Lancet*, March 14, 1874.

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*Chloral Hydrate in Gonorrhœa.*—Dr. Parona has made an extended trial of chloral as an injection, both in the gonorrhœa of men and in blennorrhagia, and speaks of its value as a sedative, and also as an astringent. The strength of the injection is one gramme, or one gramme and a half, of chloral to 100 grammes of water. The injection is used three times a day, and retained as long as possible. The best time to commence it is when the acute symptoms are subsiding, and it then not only relieves the pain and distress on passing water, but also removes the discharge. — *Giornale Ital. delle Malattie Venerée*, and *Med. Times and Gazette.*

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*Podophyllin in Habitual Constipation.*—Van den Corput recommends the following formulæ. 1. Podophyllin, 20 centigrammes; soap, 1 gramme; essence of fennel or of canella, as many drops as are sufficient; the mass to be divided into ten pills, of which from two to four are taken daily. 2. Podophyllin, 30 centigrammes; extract of nux vomica, 50 centigrammes; extract of belladonna, 30 centigrammes; to be divided into ten pills, of which two or three are a daily dose.—*Brit. Med. Journ.*, Feb. 14, 1874.

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*On the Treatment of Alcoholism by Nux Vomica.*—Dr. Luton (*Mouvement Médical*, Dec. 1873) describes excellent effects from the use of nux vomica in chronic alcoholism, where the evil has not passed into the absolutely degenerative stage of tissue-change. In the tremors, cerebral disorder, and gastro-intestinal and thoracic disorders of alcoholism, he resorts with confidence to the use of extract or tinc-

ture of nux vomica in ordinary doses.—*Lond. Med. Record*, March 18, 1874.

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*Parenchymatous Injection of Carbolic Acid.*—Hüter strongly recommends the injection of a two per cent. solution of pure carbolic acid in water as the most active antiphlogistic remedy for all forms of parenchymatous inflammation. He makes the injection in the position where the lymphatics bring the acid in direct contact with the inflamed tissue. The result of such parenchymatous carbolic injection he describes, from experience, as being miraculous; and he says there are no material impediments to its use in organs such as the lungs, spleen, etc., but he has not as yet practised it in these viscera.—*Irish Hospital Gazette*, April 1, 1874, from *Centralblatt*, Jan. 24.

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*Carbolic Acid, Subcutaneously, in Erysipelas.*—Dr. Aufrecht, of Magdeburg, describes the result of subcutaneous injection of carbolic acid solution (1 per cent.) in two cases of erysipelas as being most striking. Both patients, in which he used the method, were very old. The injections were repeated four and six times.—*Ibid.*, from *Centralblatt*, February 21.

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*Fuchsin as an Antiseptic.*—This anilin preparation is said by Laujanois, in the *Comptes Rendus*, to be a remarkably powerful antiseptic. One per cent. added to a solution of gelatine, not only preserved it, but a piece of fresh meat wrapped in paper soaked in this medicated gelatine solution kept for months without a sign of putrefaction. One forty-thousandth part ($\frac{1}{40,000}$) added to urine, prevents it perfectly from decomposing. Such experiments merit careful repetition.—*London Med. Record*, Jan. 7, 1874.

—

*Alcohol as a Constituent of the Urine.*—After observations made upon individuals subjected to a rigid abstinence from alcoholic drinks, M. Bechamp concludes that the urine of man contains an appreciable quantity of alcohol as a normal element. It is produced, he believes, physiologically, by the liver.—*Irish Hosp. Gaz.*, Dec. 15, 1873.

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*Double Ureter.*—Dr. W. G. Smith exhibited at the Pathological Society of Dublin, Jan. 10, 1874 (*Irish Hosp. Gaz.*, Jan. 15, 1874), an instance of the above rare abnormality which he had found in a dissecting-room subject. The double ureter was on the right side; the left kidney and its ureter were normal.

—

*Congenital Alopecia.*—Lebedi publishes in Langenbeck's *Archiv* (vol. xiv.) two cases of congenital alopecia. In a piece of skin excised from the scalp, the sebaceous and sudoriparous glands were found normal, and there were also follicles which resembled those of the hair and were provided with arrectores muscles, but showed no trace of a bulb.—*London Med. Record*, Feb. 11, 1874.

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*Case of Trichiniasis.*—Dr. Coupland exhibited, at a recent meeting of the Pathological Society of London (*Lancet*, January 17, 1874), muscles affected with trichinæ. A man, aged thirty-three, died in Middlesex Hospital with chronic phthisis and recent acute bronchitis. The muscles were extremely wasted, and he suffered from extreme orthopnœa. At the post-mortem all the voluntary muscles contained calcified trichinæ, also the diaphragm and intercostal muscles, and one muscle of the internal ear, the tensor tympani. The heart was not affected. He calculated that about seventy-five millions of trichinæ were present in the muscles. In one cyst there were found two trichinæ. It was probable that the patient caught the disease nine years ago, when in New York, where he suffered from a severe attack of what was called "enteric fever."

Dr. Greenhow said it was a very rare case. He had been struck with the extreme emaciation of the muscles of the chest and the deficient expansion of the thorax; he thought the patient died as those do who suffer from muscular atrophy. The bronchial disease was slight, but he had little power of expectorating.

*On the Influence of Posture on Pre-systolic Murmurs.*—In an interesting article in the *Practitioner* for Dec. 1873, Dr. W. R. Gowers calls attention to the influence of posture in altering or removing cardiac murmurs, and particularly the so-called "pre-systolic" mitral murmur. Several cases have come under his notice, in which, after a careful and skilled examination in the erect posture, a heart has been declared free from murmur, when, had the patient been made to lie down, a bruit would have been heard which could not have been overlooked. Dr. Gowers believes, that in most instances the murmur which precedes the first sound, and is commonly regarded as characteristic of mitral obstruction, is both louder and longer in the recumbent than in the erect posture, and that, in many instances, more frequently than in the case of any other cardiac murmur due to an organic cause, it may be heard in one posture and not in another, may be loud when the patient is lying down, and inaudible when he is standing up.

—

*Excision of Scapula.*—Mr. O'Grady removed the entire scapula on the 20th of Jan., at Mercer's Hospital, for cario-necrosis, from a young man, aged 19. Some three inches of the head and shaft of the humerus of the same side had been over a year previously removed by the same operator. The case is progressing favourably.—*Irish Hosp. Gaz.*, Feb. 2, 1874.

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*The Rate of Mortality after Amputations.*—Mr. John Eric Erichsen, in his first lecture on Hospitalism, stated (*British Med. Journ.*, Jan. 17, 1874) that the rate of mortality after amputations in hospital practice still continues to be very high, and that it has not decreased since the publication of the first amputation statistics in civil practice about thirty-five years ago.

—

*Rupture of the Bladder.*—Mr. Morgan exhibited to the Surgical Society of Ireland (*Irish Hosp. Gaz.*, Feb. 2, 1874), an example of the above injury. The day before the patient, from whom the specimen was obtained, was admitted into hospital, he had, while under the influence of drink, fallen on his face when going into a yard for the purpose of passing water. Owing to a stricture of the urethra, a No. 5 catheter only could be passed, and by it some bloody urine was drawn off. Symptoms of peritonitis set in, and the man died on the fifth day after the accident. The walls of the bladder were much thickened; the rent, which was a large one, was situated, as is usual, at the upper part of the viscus. Two portions of intestine lay against, and were partly adherent to, the bladder. The case was remarkable (1) from the occurrence of a rupture in a diseased bladder; (2) from the size of the rent; and (3) from the time the patient lived after the injury.

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*Mustard Plaster.*—It is stated in the *London Medical Record* (February 25, 1874), that, in making a mustard plaster, no water whatever should be used, but the mustard mixed with the white of an egg; the result will be a plaster which will "draw" perfectly, but will not produce a blister even upon the skin of an infant, no matter how long it is allowed to remain upon the part.

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*Lusus Naturæ.*—Dr. W. H. Bent, of Argyle, N. S., reports the following peculiar case of monstrosity occurring in a child whose parents reside in Pubnico. It has three legs in perfect use, two complete sets of sexual organs (male); two perfect arms, and two imperfect ones—the latter growing from the middle of the back and curving in a line with the lower ribs. The head is finely developed, and what appears to be a second one is situated half way down the left side of the neck. It is considered a great wonder among the French Acadians.—*London Med. Record*, Jan. 7, 1874.

Dr. Depaul presented to the Academy of Medicine, of Paris, a most interesting monstrosity, in the shape of a little girl of five or six years bearing on her abdominal walls the hindpart of a child's body. M. Hervieux was appointed to investigate the case and report on it, and he has just sent in his report. According to him, this *lusus naturæ* is not an instance of mon-

strosity through inclusion, but must take rank among Geoffroy St. Hilaire's class of "polymelians," characterized by the insertion of one or several redundant limbs on a well-formed body. In this instance, the redundant part shows no genital organs or anal orifice; the limbs are of unequal growth, the joints are anchylosed, and all the parts show little vitality and sensibility. The two bodies are joined together by a large base, both pubes being attached together; but movements are extensive enough. The soft parts seem to constitute a fatty mass, without muscles, tendons, or aponeuroses. It is very likely that the abdominal viscera are absent. The little girl is quite healthy, and well developed; but there is no doubt that the tumour is a great hindrance, and may continue to develop, so that, in view of the above circumstances, Dr. Hervieux arrives at the conclusion that surgical interference is possible and necessary, and that the growth should be cut off. It would seem, however, that the girl's relatives are much more disposed to exhibit this unfortunate *lusus naturæ* than to give her the benefit of an operation.—*Lancet*, Jan. 17, 1874.

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*Duration of Human Life.*—The mean duration of human life has notably increased. There exist at Geneva mortuary records, kept with great exactitude, from the year 1650. A comparison of the figures in this record shows that the mean duration of life at the period mentioned was 22½ years; it is now 40 years and 5 months. It has thus doubled in less than three centuries. In the fourteenth century the average of deaths in Paris was 1 person in 16; it is now 1 in 32.—*L' Union Médicale*, March 14, 1874.

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*New Sign of Death.*—M. Bouchut stated at the Académie des Science that at the moment of death gases which are normally imprisoned in the venous blood are disengaged, forming a pneumatosis of the veins. The pneumatosis of the veins of the retina is easily appreciable by the ophthalmoscope, and constitutes an immediate and certain sign of death. This pneumatosis is indicated at the moment of death by the interruption of the column of blood in these veins—a phenomenon similar to that which is observed in the interrupted column of a thermometer with coloured alcohol.—*Med. Times and Gaz.*, March 21, 1874, from *Gaz. des Hôp.*, March 10.

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*Parisian Medical Journals.*—It is stated (*Archives Generales de Méd.*, March, 1874) that there are no less than thirty medical periodicals published in Paris at the present time, the titles of which are given. Of these three are issued quarterly, one every two months; seven monthly, and the remainder at shorter intervals.

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*Professor Hyrtl.*—It is announced that Dr. Hyrtl, the well-known Professor of Anatomy in the University of Vienna, is about to retire from the chair which he has so long and worthily filled.

—

Obituary Record.—Died, at his country seat near Limoges, on the 7th of March, of acute pneumonia, aged 83 years, Prof. Cruveilhier. Prof. C. was a pupil of Dupuytren, succeeded Béclard as Professor of Anatomy in the School of Medicine, and occupied afterwards the chair of pathological anatomy created by a legacy of Dupuytren. He was the author of many most valuable works, among which may be enumerated, *Traité d'Anatomie pathologique générale, avec atlas; Traité de Médecine pathologique, Anatomie descriptive*, etc. His novel observations were numerous, as those regarding simple ulcer of the stomach, fibrous tumour of the mammæ, the anatomical characteristics of cancer, progressive muscular atrophy, etc., attest.

He occupied in his day a lofty eminence in the profession, and was justly greatly esteemed not only for his scientific attainments, but also for his modesty and benevolence.

——In Paris, March 18th, of apoplexy, Dr. Joulin, principal editor of the Obstetrical Journal (*Gazette de Joulin*), and Prof. of Midwifery at the School of Medicine.

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on Strangulated Hernia.* By JOHN W. HULKE, F.R.S. Delivered at Middlesex Hospital.

GENTLEMEN: No accidents are more deserving of your closest attention than strangulated ruptures, for it is scarcely an exaggeration to say that no two are alike in all their circumstances, and upon your prompt appreciation of these will mainly depend your patients' rescue from a condition which, when unrelieved by art, is so desperate, so nearly hopeless, that it well deserved the name our forefathers gave it—a "*miserere.*" There have been lately in Broderipp ward two cases which it will not be unprofitable for us now to review.

The first is that of a muscular, healthy carpenter, aged 27, who was admitted into Broderipp ward at 4 A. M., October 14, 1873. The right side of his scrotum was distended by a very large, extremely tense, globular swelling, which below concealed the testis, and above was continuous with an oblong portion in the inguinal canal. When he coughed, no impulse was communicated from the belly to the scrotal tumour. It and the belly were very tender, and so painful that he writhed restlessly about in bed and begged for something to be done speedily to relieve his suffering. He frequently retched. His face was pale, and its expression anxious. His pulse was quick and small.

He had had a rupture for many years; it had sometimes come down, and until now he had always managed to replace it.

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Latterly he had worn a truss. The rupture had slipped down at midnight; he could not get it back; it directly became extremely painful. He began soon after to vomit, and felt very ill.

At five o'clock, when I saw him, he was at once placed under the influence of chloroform, and, when complete relaxation was obtained, the taxis was tried for a few minutes. Not being successful, without further loss of time the hernia was operated on under a carbolized spray. A cut, about three inches long, was made in the long axis of the tumour, with its centre over the depression which marked off the scrotal swelling from that in the groin. When the external inguinal ring, where the seat of the strangulation was expected to be, had been notched, and some tight threads of fascia transversalis upon the outer surface of the sac had been cut, another attempt was made to reduce the contents. It failed, and the sac, which was very thin and transparent, was opened. A coil of dark purple intestine came clearly into view. The finger could be passed upwards through the internal ring without meeting any obstacle, yet still reduction was impracticable. The impediment now appeared to be in the scrotum; and on passing the finger downwards, at about one inch from the lower angle of the wound, a sort of transverse diaphragm was found dividing the scrotal part of the sac into an upper and a lower compartment, which communicated by a small circular aperture. When this had been notched, and a recent adhesion of the gut just above it had been separated, several coils of small intestine, almost black, and spotted with many small hemorrhages, were easily drawn out of the lower compartment and reduced. They were lying upon the testis. The wound was washed out with a watery solution of 1 per cent. of carbolic acid, closed with wire stitches, and dressed antiseptically. He was ordered one grain of opium at intervals, the length of which was to depend on pain. The wound healed almost wholly at once; a very slight inodorous, sero-purulent discharge oozed for a few days from the upper angle. The bowels first acted on the 21st, and until then he was restricted to a milk diet. At the end of the month he was convalescent.

The next case is that of a large, heavy brewer's drayman, aged 23, also lately in Broderipp ward. He had had a rupture since childhood, but he had never worn a truss. At long intervals the rupture had occasionally slipped down, but until now it had always been reducible. At 4 P. M. whilst hurrying to catch a train, he felt it pass into the scrotum; and he was directly seized with great pain followed by sickness. His attempts to reduce the rupture failing, and his suffering becoming very great, at 7 P. M. he was brought to the hospital. When I saw him (four hours after the accident) the right side of his scrotum was distended by a very tense rupture, about a span long, separated by a shallow groove at the external abdominal ring from an upper portion filling the inguinal canal. The scrotal part did not receive any impulse from the belly when he coughed. The testis could be plainly felt at the bottom of the scrotum, distinct from the rupture behind it. He was bent double with pain in the belly and rupture —the latter, too, was so tender that he could not bear it to be handled; and he was sick. We at once gave him chloroform, then tried the taxis for a few minutes, and, not succeeding by it, operated.

When the external ring, where the strangulation was expected, had been notched, an attempt was again made to reduce the contents without opening the sac, but this could not be effected. The sac, as thin as tissue-paper and quite transparent, was then opened. It contained a large piece of omentum slightly congested, and behind this several coils of dark-purple small intestine. The obstacle to reduction was found to be a couple of tight fascial threads crossing the neck of the sac and blended with it; after their division the intestine and omentum were returned without difficulty. The sac also contained about two ounces of bloody serum. Antiseptic precautions were taken during the operation, and the wound was dressed antiseptically. It healed almost entirely at once; there was a slight suppuration only in one suture-track. The

first stool was not passed until the fourteenth day, when, the belly being rather uneasy, a simple enema was given, which brought away many scybalæ About a week later, when quite convalescent, he had looseness, with tenesmus, caused by impaction of feces in the rectum. It ceased on their removal, and a couple of days afterwards he returned to work.

These, gentlemen, are pattern cases of large, acutely strangulated ruptures in young muscular subjects. In the first patient recourse was had to herniotomy five hours, in the second four hours, after the accident. To some of you this will perhaps have appeared a hasty proceeding, and you would like to ask me why we did not give the taxis a longer trial and put the patient into a hot bath; why the effect of a full dose of opium and of ice upon the rupture was not tried before operating —measures which you have known successful in other cases. The reply is, that when unsuccessful these measures have entailed a loss of time which in acute cases is very perilous; and here the ruptures were so tense, presumably therefore the strangulation so tight, that the chance of their succeeding was almost *nil*. It is in the less acute strangulations, where a few hours' delay in operating does not much increase the danger, that they find their proper place. Experience has only strengthened my conviction that abuse of the taxis has contributed in no small degree to swell the mortality after operations on strangulated ruptures. I speak not merely of a misplaced confidence in it, by which precious time is lost, during which the patient's condition drifts into constantly increased dangers, but of injuries inflicted by the use of force unwarrantable in degree and faulty in direction. Two cases which I watched with intense interest made a lasting impression on my mind. I will briefly relate them as warnings to you.

A young widow, ruptured four years, wearing a badly-fitting truss, had her rupture slip down and become strangulated. For three days her medical attendant assiduously persevered with the taxis. At last she was brought into a hospital. In her right groin was a large, tense, tender crural rupture. She complained of a dreadful screwing pain in the belly at the navel, and of great thirst, and she vomited a pale coffee-coloured, fecal-smelling fluid. The house-surgeon put her into a hot bath and repeated the taxis, with the result that the contents of the rupture suddenly slipped up into the belly. She instantly cried out with excruciating pain above the pubis, she exclaimed that she thought her bladder had burst. Two hours later the pain was, if possible, still more intense, and her suffering was heightened by a sensation of distension, as if her belly were about to burst. Her face was pale, her features pinched and sunken; her pulse small, intermittent, weak, and so rapid that it could hardly be counted; and she retched, with little intermission, bile-coloured matters.

The sudden way in which the contents of the rupture went up into the belly, raised the suspicion that possibly they might have slipped up through the crural opening still inclosed in the sac, and constricted by its neck (reduction *en bloc* or *en masse* as it was named by Claquet). It was ascertained by an exploratory operation that this mishap had not occurred. She died seventeen hours after the reduction of the rupture.

At the examination of her body the sac and the tissues around it were found in a nearly gangrenous condition. Six inches of the ileum were gangrenous, and in this part was a small hole through which feces had run out into the peritoneal cavity. The pelvis contained about a pint and a half of a turbid, yellow, feculent-smelling serum, and there were evidences of an intense general peritonitis. Had this woman's rupture been operated on early instead of being repeatedly submitted to the taxis, she would probably have recovered; and even on the fourth day—by which time its contents had become gangrenous—had the taxis not been repeated, but herniotomy been done, and the sac opened, the gangrenous condition of the strangulated intestine would have been ascertained, a safe outlet for its contents might have been made, and recovery with an artificial anus been still possible. As it was, misuse of the taxis allowed the

gut to become gangrenous, then burst it, and killed her.

Several years later I witnessed another case where I could not resist the conviction that the patient's death was directly due to violent manipulation. The rupture was umbilical, very large, of several years' formation, during which the patient, a stout middle-aged woman, had been plagued with dragging pains, and with retching, which were relieved by simple domestic measures. At last strangulation occurred, and her condition growing desperate, additional advice was obtained. Happening to go in, I saw the surgeon standing upon a stool, bent over his patient, energetically kneading the rupture with, as it seemed to me, a dangerous expenditure of force. She suddenly swooned, and in a few moments life was extinct. At the examination of her body, her stomach, much dilated and thinned, and partly drawn into the rupture and entangled in it by adherent omentum, was found burst; the rent was extensive, and the contents were diffused through the peritoneal cavity.

I have, also, several times found the skin red and ecchymosed, and the superficial cellular tissue so much more congested than that nearer the sac, that I felt constrained to refer these disorders to external injuries, and not to any spread of inflammation from the rupture to the surface. The lesson which cases such as these and the two I have just related convey is that any handling of a strangulated rupture should be very gentle. The only justifiable taxis is a gentle, uniform, steady compression, combined with an equally gentle pushing in the direction of the channel through which the viscera have protruded from the belly. This, whilst far safer, is also much more efficient than the forcible jerky squeezing occasionally witnessed.

To return to our two cases. You will have remarked that they have several common features and one notable difference. Both patients were young muscular men; in both the local and also what are termed the "general" or "constitutional" symptoms were urgent; the nervous commotion, pain in belly, and sickness were great, and the morbid changes in the strangulated viscera were already very considerable, although so short a time as only four hours in one and five hours in the other case had elapsed. In the first rupture the intestine in the sac was even more excessively congested than in the second. Two circumstances conduced to this—first, the contraction of the inguinal ring consequent on the recent use of a truss; and next, the existence of a double strangulation, one at the external abdominal ring, the other in the sac occasioned by the sharp edge of the circular partition which divided this into an upper and a lower compartment. You will recollect that the intestine in this compartment was even more congested and more spotted with extravasated blood than that in the upper space between this partition and the external ring. You will also have noticed that the intestine was directly in contact with the pelvis—in short, that the hernial sac was the tunica vaginalis testis (the obscuration of the testis by the rupture raised the suspicion of this before the operation)—the characteristic of the variety of rupture named "congenital," because conditioned by the persistent openness of the tube of peritoneum, which the testis draws after it in its passage from the loins into the scrotum, in the eighth month of fœtal life, and which, soon after the testis has left the external ring, normally begins to be obliterated and converted into a solid fibrous band.

The partitions in the upper part of the sac, so frequent in congenital hernia (I have several times met with one, and more than once found two), probably have their origin in incomplete obliterations of this peritoneal tube. Their presence is an additional complication, and it may, perhaps, partly explain the much greater danger of strangulated congenital ruptures than of herniæ acquisitæ of similar bulk and at the same time of life—a circumstance so pointedly mentioned by Dieffenbach in his *Operative Chirurgie*, a book I cannot too strongly recommend you to read.

In our second case the hernial sac was distinct. Formerly this would have been regarded as a *hernia acquisita*—one whose

sac was a new bag of peritoneum pushed before them by the protruding viscera; but the early age at which the rupture first appeared, renders it very probable that it was really only a sub-variety of congenital hernia, in which the congenital peritoneal tube had been obliterated only just above the testis, so separating its dilated testicular part (now the tunica vaginalis) from the tubular part above, which remaining unclosed admitted the intestine into it, and became its sac. In connection with this, I would refer you to Mr. Birkett's article on hernia in Holmes's *System of Surgery*. The progress of both cases after the operation was all that could be desired. The symptoms of strangulation at once ceased, and those who saw only the calmness of the following day could scarcely realize the critical state which had so shortly preceded it. There was very slight febrile disturbance, and the wound healed almost wholly by first intention. How far this should be ascribed to the antiseptic precautions I cannot say, but I would lay great stress here, as everywhere in surgical operations, on the necessity of absolute cleanliness. To both patients opium was given, not in fixed doses and at stated times, but in quantity from half a grain to a grain, and at intervals entirely dependent on the existence and the degree of pain. This, which has been my practice many years, has afforded me very satisfactory results; it tranquillizes, and it keeps the bowels quiet. In one of our two cases no stool was passed until a week, in the other till a fortnight had passed. This did not occasion us any anxiety, and the only inconvenience resulting from the prolonged inactivity of the bowels was a slight impaction of accumulated feces in the rectum —an affair of very small importance. Do not take my remarks as a sanction to give opium necessarily in all cases; this would be a blamable want of discrimination. To some patients you will not need to give a single grain; to others you must give it boldly, but with judgment.—*Med. Times and Gazette*, April 4, 1874.

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*Abstract of a Lecture on Puerperal Eclampsia*, delivered at the Hôpital Saint Antoine, Paris, by M. PÉTER.—Puerperal eclampsia is one of the most important affections in obstetric pathology, and has always been a subject giving rise to endless controversies and experiments, mostly from the etiological, pathogenetic, and natural points of view. M. Péter, whose post at the St. Antoine Hospital allows him exceptional opportunities for studying this disease, has given two most interesting lectures upon it, of which we present the following summary. In the course of his lectures M. Péter strongly recommends the perusal of the excellent article by M. Bailly, in the lately published *Dictionnaire de Médecine et de Chirurgie Pratiques*, to which he renders a just meed of praise. It is constantly advanced as a fact that all pregnant and eclamptic women are albuminuric; that the albumen may disappear for some hours, and that eclampsia in pregnant women without the presence of albumen forms a very rare exception. Thus there may have been recorded six or seven cases of eclampsia without albuminuria.

Two questions immediately arise. The first is what is the reason of this frequency? To this the reply is, that there is a larger mass of blood in circulation. The second is, as to whether cases of eclampsia have become more common during the last thirty years. To this the evidence of statistics gives an affirmative reply. The hypertrophy of the heart during pregnancy shows the increased amount of blood in circulation. The demands of the uterus are augmented, and the blood of the mother has to supply the nutrition of the fœtus. Therefore the maternal organism ought to benefit by this larger volume of blood; and, as a matter of fact, the woman does present both the appearance and the reality of plumpness. This fact being established, what then are the accidents which are likely to occur in such a contingency, the organs liable to be affected being the lungs, liver, and kidneys?

With regard to the lungs; as the mother is obliged to make blood for two, we find pulmonary oppression, and when this symptom is increased, hæmoptysis. If the heart be diseased, with presumable

mitral insufficiency, we meet with double pulmonary congestion. These facts declare themselves, and these accidents appear towards the fifth month of pregnancy. With regard to the liver, we generally find simple icterus; acute icterus is uncommon.

We now proceed to consider the accidents to which the kidneys are liable during the pregnant state. In the same way as the mother makes blood for two, so she makes urine for two. The analyses of the urine and its elements demonstrate that there is a larger quantity of urea in the pregnant woman; and M. Quinquaud has found that, instead of 22 to 24 grammes in the twenty-four hours, she eliminates 30 to 38 grammes of this substance. A larger quantity of blood implies greater pressure, and consequently more filtration, when not only albuminuria, but discharge of serum with the urine occurs.

According to the writings of Charles Bernard and the negative deductions he has drawn from his experiments, urea is not the cause of eclampsia, any more than is carbonate of ammonia. Neither is it uræmia, nor ammoniæmia, nor creatinæmia; but, according to M. Péter, creatinæmia. M. Quinquaud, who has made three analyses, found, instead of 6 parts of extractive matters, 21 per cent. in the first, 19.2 per cent. in the second, and 18.3 per cent. in the third.

The frequency of puerperal urinæmia has been increasing, a fact proved by M. Charpentier's inaugural thesis, in which he gives the following statements compiled from the records of the Hopital des Cliniques during thirty-eight years: From 1834 to 1843, seventeen cases; for 1844 to 1853, twenty-seven cases; from 1854 to 1863, thirty-five cases; from 1864 to 1871, fifty-four cases.

MM. Andral, Gavarret, Becquerel, Rodier, and Reynauld have demonstrated that pregnant women have fewer red corpuscles, whence it has been concluded that all pregnant women are anæmic. M. Reynauld has analyzed the blood of thirty-four pregnant women; the normal state of the blood-corpuscles is 127 per 1000, but this observer counted 145 in one instance, 127 in another, from 125 to 120 in six cases, and from 120 to 195 in twenty-six. Thus it is evident that one-fourth escaped anæmia; besides which, before having arrived at that conclusion, it would have been necessary to analyze the blood of those women before they had reached their physiological state for the time being, in view of the anæmia possible before, during, and after pregnancy. The anæmia of pregnant women does not rest on any logical interpretation, and tocologists commit a *petitio principii* when they refer pulmonary oppression, spitting of blood, and albuminuria to anæmia, by referring the eclampsia of pregnant women to anæmia of the bulb. This affection has also been termed serous plethora, a term to which we give our adhesion; but then the patient has serous blood; that is to say, blood less rich in corpuscles, giving rise to congestions of the liver and kidneys, which leads to icterus, voiding of serum, etc. If the bile were secreted by a gravidly congested liver, M. Péter believes that we should find in it serum, leucocytes, and blood-corpuscles.

The question is briefly as follows. Must we prevent congestion in the region of the kidneys? To answer this question, we must divide it into two branches: 1. How to foresee the accidents; 2. How to prevent them. For the first object, M. Péter recommends that the urine of all pregnant women should be examined. If, on the one hand, he note the presence of serum towards the fifth month, and, on the other, symptoms of cephalalgia, he is on his guard. The headache is very painful; it is seated in the anterior portion of the cranium, rarely in the occiput; at first it is fugitive, only appearing at certain times, and subsequently becomes persistent. "Unhappy is the patient," says M. Péter, "in whom this symptom becomes persistent."

After headache, visual troubles come on, troubles which consist in a difficulty of grasping the outlines of objects. The patient is unable to read for many minutes at a time, and she vomits if she wish to continue reading. She sees coloured spots (irisation) in consequence of want of accommodation, and may subsequently

be affected by amblyopia, hemiopia, or amaurosis, going on to total blindness—a stage when the attack of eclampsia is not far off. The ophthalmoscope gives no indication; the transparent media are intact, and there is nothing in the retina. The hyperæmiæ, which cause these functional troubles, occur in the cerebral centres. M. Bailly has observed a little suffusion in the conjunctiva, especially at the level of the oculo-palpebral folds, a kind of serous chemosis.

There are other prodromata equally conclusive with those already enumerated, one of them being a feeling of oppression at the epigastrium, as if there were continuous pressure on the epigastric cavity. This may probably be a species of aura seated in the pneumogastric nerve, a view of the case warranted, in M. Péter's opinion, by that other important and significant phenomenon, dyspnœa. Vomiting forms another highly important symptom. The attacks are frequent, and the matter ejected consists of stomachic mucosities, bile, and food, when the sickness comes on after a meal. Finally, vertigo, dulness of the intellect, insomnia, or comatose sleep and restlessness, are observed.

Having thus enumerated the prodromata of the eclamptic attacks, M. Péter proceeds to consider the causes of urinæmia, which have been classified as: 1. The compression of the inferior vena cava and the renal vena by the gravid uterus; 2. Double pregnancy; 3. Triple pregnancy; 4. Rickets. These eclamptic attacks mostly come on from the fifth to the ninth month, and especially in the ninth month.

On this point M. Péter's conclusion is, that the congestion is in direct relation to the quantity of blood in circulation, and the quantity of blood is in direct relation to the double or triple alimentation which the maternal organism is obliged to bear, and which it must supply. The greater the functional need the greater the purificative need; whence arises a functional hyperæmia in proportional relation to the needs of two or three organisms. M. Péter, taking heed of the most salient facts, recommends bloodletting as a preventive measure, which is also advised by Cazeaux and Beau. The latter only takes away 60, 90, or at the most 120 grammes; M. Péter makes his minimum quantity 150 grammes, with the addition of the removal of blood by cupping in the region of the kidneys.

Bloodletting is also extolled as a curative measure by M. Péter, MM. Depaul, Dubois, and Cazeax; it does not always cure, but it is sure to give immediate relief. In reference to this practice, Holz wrote to M. Charpentier that "of all the means employed, bleeding has proved the least unreliable."

A second method is to give emetics in contra-stimulating doses (*doses raisoriennes*). The third plan is the use of anæsthetics, particularly chloroform, a plan which has its partisans, its neutrals, and its enemies; that is to say, it has been powerful in the hands of the first-mentioned, useless with the second, and mortal when employed by the last. As surgical treatment M. Péter recommends artificially induced accouchement, especially where the medical treatment has failed.

Eclampsia is a most serious affection. A great proportion of the sufferers from it die, and if they recover the cure is not complete, and Bright's disease is a certain result. Amongst all the accidents to be dreaded as likely to carry off the patients, one of the most serious is uterine hemorrhage, a result of the typhization of the blood, an accident first observed by Blot, and which cannot be arrested by any expedient whatsoever.—*London Medical Record*, April 1, 1874.

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### HOSPITAL NOTES AND GLEANINGS.

*Neuralgia treated by Phosphorus.*—Dr. Bradbury has in the out-patient department of Addenbrooke's Hospital, Cambridge, been lately testing the value of phosphorus in neuralgia. On the whole, he has met with considerable success from its administration. The following are two cases in which the drug effected a cure when other remedies had failed.

Case I.—E. P., aged 24, single, shopwoman, living in Cambridge, was first seen on October 29th, 1873. She had

suffered from trigeminal neuralgia of the left side for three months. As the bowels were confined, and she was somewhat anæmic and the catamenia scanty, a draught containing one grain each of sulphate of iron and sulphate of quinia, five minims of dilute sulphuric acid, and half a drachm of sulphate of magnesia, in an ounce of peppermint-water, was ordered thrice daily. She persevered with this mixture till December 22d, with only slight improvement. On this day the pain was very severe, and she was ordered a phosphorus capsule (= one-thirtieth of a grain of phosphorus), to be taken twice daily after food. After taking two capsules, the pain entirely ceased; and on January 12th, 1874, the patient was discharged quite well, having had no recurrence of the neuralgia.

Case II.—E. H., aged 40, married, and living at Haslingfield, first came as outpatient on November 26th, 1873. For eight weeks she had had very severe trigeminal neuralgia, her features being expressive of great suffering. She was suckling her baby, although the child was fifteen months old. She was directed to wean the baby, and to take a mixture containing two grains of quinia and fifteen minims of tincture of sesquichloride of iron in an ounce of water twice daily. On December 6th, there was no improvement. As cases of ague had been admitted from this locality, Dr. Bradbury thought it possible the neuralgia might be of a malarious character, and ordered a mixture containing five minims of solution of arseniate of soda, one drachm of tincture of hop, and half an ounce of water, to be taken thrice daily, with the meals. A chloroform and belladonna liniment was also prescribed to be applied to the painful part. When next seen (December 20th), she was as bad as ever, so a phosphorus capsule was prescribed, to be taken thrice daily after food. The patient was also ordered to rub into the temple every night a little aconitine ointment. The relief from this treatment was most marked; and when the patient was last seen, on January 31st, 1874, there had been no recurrence of the pain for more than a month.—*Brit. Med. Journal.*, March 14, 1874.

*Rheumatism of the Tendons.*—Under the care of Dr. PETER at Hôpital St. Antoine, Paris. The patient, aged thirty-five, had been suffering for a few days from pain in the situation of the joints of the knees and ankles. No swelling or redness was to be observed in the painful situations; no general symptoms of rheumatism; no fever. The pain was developed when the finger was moved carefully along the head of the fibula, on the tibia in the situation of the aponeurotic expansion of the tendons, and behind the malleoli. Movements of the articulations were painful through the straining exerted on the inflamed tendons.

M. Peter has often observed such cases of rheumatic inflammation of the tendons and serous bursæ, unconnected with gonorrhœa. The pain is to be sought after, not with the hand, but with the finger, carefully exerting pressure on the situation of the tendons and bursæ—for example, behind the ankles, between the biceps and head of the fibula, above the aponeurotic expansion of the knee, behind the calcaneum and the olecranon, in front of the patella, in the situation of the great trochanter, etc. The disease is really an extenuated form of rheumatism, and constitutes rheumatic synovitis. It rarely presents cardiac complications. It is seldom accompanied by any great fever, though sometimes the fever may be somewhat high, and the evening temperature may rise to 39° or 40° Cent. There may be slight œdema or not in the situation of the inflamed tendons. Likewise the surface may be discoloured or not. It is much milder than articular rheumatism, and does not require any energetic treatment.—*Lancet*, March 28, 1874.

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*Hemorrhagic Smallpox.*—Dr. A. EWALD, of Charité, Berlin, reports (*Irish Hos. Gaz.*, April 15, 1874) the following case:—

On Feb. 26, a young man, aged 21, who gave the following history, was brought into the Clinique of Prof. Frerichs. On the morning of the preceding day he had been attacked with slight pain in the head and back, which did not, however, prevent him from following his busi-

ness as a painter. Gradually the pains became more severe, and there appeared small, isolated, red spots on his chest and abdomen. The number of these spots increased most rapidly during the night. He was then attacked with great weakness and lassitude, and, when admitted, was no longer able to walk or stand; he had had no palpitation of the heart, no cough nor pain in the throat; till the day before his admission he had always been healthy.

On examining the patient, who was a strong-built, well-developed man, though at the time in a state of great prostration, what at once riveted the attention was a copious purpura-like eruption, the hemorrhagic spots forming which were about the size of split-peas, and of a brown or bluish-red colour; they were most numerous in the hypochondriac region and about the groins, in which situations they coalesced and formed islands of bluish-red ecchymosis. They were much less numerous along the inner side of the extremities, though somewhat more plentiful in the neighbourhood of the joints, and there were few on their outer surface; the face remained quite free. Both the ocular and palpebral conjunctivæ were, however, bulged forward by a reddish-brown infiltration, looking like chemosis. All the spots were true hemorrhages, and nowhere was there the slightest elevation of the cuticle, or the least attempt at the formation of a pustule or vesicle, except on the dorsum of the right foot, where there was a vesicle about the size of a split-pea, which was filled with an opaque whitish fluid; the centre of this vesicle was not, however, in the least depressed. There was slight hemorrhage from the gums, but a cursory glance at the interior of the mouth and fauces detected nothing abnormal. An examination of the internal organs failed also to discover any structural changes. The heart sounds were healthy, the pulse of average fulness and compressibility, and there was no elevation of temperature. The treatment consisted in the administration of large doses of ergot, and some wine, with a cold compress over the eyes. In spite of these measures, however, the symptoms of debility gradually increased, and the patient was dead within two hours.

We were greatly helped, in forming our diagnosis of this case, by being able to exclude two diseases, the symptoms of which are very similar to those just described, viz., scorbutus, and endocarditis with numerous embolisms in the skin (the rapid course of the disease contra-indicating them both, the absence of all heart symptoms more especially the latter). There only remained, therefore, for our consideration, the large group of acute exanthemata, in severe cases of which, as is well known, similar hemorrhages have been observed during the period of invasion. If the symptoms, and more especially the pustule on the dorsum of the foot, made it very probable that the case was one of variola hemorrhagica, this probability became a certainty when, some hours afterwards, a patient, with similar hemorrhagic spots, but with typical smallpox eruption, was brought into the hospital from the same house as the former. This latter patient was at once transferred to the smallpox ward.

The *post-mortem* appearances found in the former case confirmed, as far as they went, our diagnosis. There were numerous extravasations of blood found in the cellular tissue between the muscles, as also in the serous envelope of the internal organs (pericardium, pleura, etc. etc.), but none in the parenchyma of the organs themselves, except in the testicle, in the substance of which gland there were found two extravasations about the size of peas.

The appearances found under the microscope showed that the extravasations had taken place immediately beneath the surface of the true skin, and had penetrated it to a distance of three millimetres, the epithelial layer being continuous over them. The blood corpuscles were especially numerous around the vessels of the papillæ, the hair bulbs and the sweat-glands not being involved.[1]

[1] This quite agrees with the description given by Wagner in the *Archiv für Heilkunde*, 1868, and that given afterwards by Wyss in the *Archiv für Dermatologie*, 1871. The view taken by the latter, from the great number of

The above cases are made more interesting from the fact that there have not since been any more similar ones. For it is most rare for cases of variola hemorrhagica to be met with, except during or immediately preceding an epidemic, and they occur very seldom without powerful predisposing circumstances. Prof. F. Meyer, who has had great opportunities for observation, has been kind enough to inform me that he has had similar cases among the best families. These cases, which correspond accurately to the description above given, always prove rapidly fatal. The most striking symptom is the enormous and rapidly-spreading hemorrhage, along with which we usually, though by no means invariably, find one or more pustules, with leaden-coloured contents, usually seated on one or other extremity. In no case that has been observed up to the present has, however, death followed so rapidly as in this, which is on this account one of peculiar interest.

I have since heard that the second patient who was transferred to the smallpox wards, and thus withdrawn from my care, is also dead.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Bromide of Potassium in Dental Irritation.*—Dr. J. Lewis Smith states (*Medical Record*, May 1, 1874) that bromide of potassium in cases of dental irritation in infancy is so salutary in its effects, that the gum-lancet need scarcely ever be resorted to. It should be administered in doses proportionate to the age of the child, and repeated according to circumstances. The remedy is of service in the treatment of all local diseases except gastro-intestinal irritation and renal disease, where convulsions are threatening.

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*Inhalation of a Bead; Tracheotomy.*—Dr. Sayre exhibited to the New York Pathological Society a small oblong bead, tapering at each end, which he had removed by tracheotomy from a child aged six years who had been brought to him by Dr. Cleary, of Gloucester, New Jersey. The child had accidentally inhaled the bead five days before, and when seen by Dr. Sayre presented an exceedingly anxious expression of countenance, had a constant irritative cough, and complained a great deal of pain in the chest under the sternum. The respiration was somewhat noisy, and the foreign body could be heard like a weaver's shuttle, as it struck against the glottis. Judging from the size of the bead, a companion to which was shown at the time, Dr. Sayre concluded to perform tracheotomy for its extraction. The patient was etherized and the operation done in the usual manner, assisted by his son, Dr. Crosby, and Dr. Yale. The instant the trachea was opened, the bead was coughed out, when the patient took a deep inspiration and was apparently dead. Artificial respiration was kept up for thirteen minutes before the diaphragm would act of its own accord, and then occasionally for half an hour more. A galvanic battery was for most of the time brought in requisition. Finally a piece of inspissated mucus was coughed up, which, having a cavity in its centre corresponding to the size of the bead, was evidently its envelope, or, as Dr. Sayre expressed it, its "overcoat." He supposed that the bead, at the moment it was projected from the trachea, lost its "overcoat," which covering at the first inspiration afterwards was drawn into the trachea down to the bifurcation, completely arresting the ingress of air.

Another interesting fact connected with this case was the ease with which the respiration was kept up, and for such a length of time, through the artificial opening.—*Medical Record*, April 15, 1874.

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*Nasal Polypus.*—Dr. Keyes exhibited to the New York Pathological Society (*Medical Record*, April 15, 1874) a young man upon whom he had operated for the extraction of a nasal polypus (myxoma). The growth commenced, seven years before, in the right nostril, and continued to

the blood-extravasations, that it is not so much a question of rupture of the coats of the vessels as of diapedesis, or escape of the blood corpuscles through the walls of the vessels, similar to that observed in inflammation, is probably true of the above case also.

increase gradually for four years, at the end of which time it was extracted by means of the polypus forceps. No relief followed; and the tumour, which evidently had not been extracted entire, continued to increase, and three weeks ago the patient consulted Dr. Keyes. The right nostril was then entirely occluded, and there was considerable deformity on the external aspect of the nose. An attempt was made to find the pedicle by the use of a probe, but without success. It seemed to be high up, and very long. Extraction with the long forceps was done, and as much of the tumour as could be reached was torn away. No relief followed. It was then discovered that a large remaining portion of the tumour was situated in the posterior nares. The patient being etherized, the forefinger of the left hand was introduced its whole length into the right nostril, which was unusually small and very dilatable. The forefinger of the right hand was then introduced into the mouth; the tumour, which was already well pushed back, was easily hooked backwards, and removed entire. The attachment was found high up on left side. The polypus itself contained in its substance two cavities of pus.

The interest of the case consisted in the felicitous method of operating, and in the apparent *à priori* impossibility of introducing a moderately large finger with such ease into a very small nostril.

In reply to a question from Dr. Knapp, as to whether the method of operating was original, he remarked that he had obtained the idea from Prof. Frank Hamilton, who had been accustomed to employ a similar procedure in such cases.

Dr. Sell remarked that Prof. Billroth performs the same kind of operation.

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*Villate's Mixture in Chronic Otorrhœa.*—Dr. R. R. Hopkins states (*N. O. Med. and Surg. Journ.*, May, 1874) that he has used Villate's mixture, as recommended by Dr. Poulaillon, in four cases of chronic otorrhœa, with success. The formula for that preparation, with the views of some French surgeons as to its value in caries, fistulæ, and abscesses, will be found in the number of the *Med. News* for July 1866, p. 114.

*Administration of Bromide of Potassium.*—Dr. Squibb, at a recent meeting of the New York Academy of Medicine, stated (*Medical Record*, May 1, 1874) that he always employs a watery solution of bromide of potassium of the strength of 12½ grains to the fluidrachm. The solution is always filtered, for by this precaution a solution which will remain clear is obtained.

The best vehicle for the administration of the remedy is ice-cold water. He has not found any stomach which has rejected the remedy when given in this manner. It is not well to administer it too near the digestive process. It should not be administered nearer than fifteen minutes before a meal. If given immediately before a meal, there will probably be developed evidences of interference with digestion. This is a rule which, for obvious reasons, it is well to observe, with regard to the administration of any of the alkaline salts.

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*Cancerous Liver.*—Dr. R. P. Huger, Assist. Phys. Alabama Insane Hospital, reports (*Charleston Med. Journ.*, April, 1874) a case of hepatic cancer in which the liver attained the enormous weight of 15 lbs. 10½ oz. (avoir.).

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*Virginia Medical Monthly.*—This is the title of a new journal, of which the first two numbers have been issued. It is edited by Landon B. Edwards, M.D., and the present numbers are well supplied with interesting matter.

## FOREIGN INTELLIGENCE.

*Antalgic Properties of Essence of Mint.*—Dr. Delioux de Savignac announces (*L'Union Médicale*, 21 April, 1874) that the essence of mint applied externally to a part affected with neuralgia will completely relieve the pain. The Chinese made this discovery years, perhaps centuries, ago. (See No. of this Journal for Jan. 1871, p. 14.) We have repeatedly used the oil of peppermint, applied locally, for neuralgic and rheumatic pains and for migraine, and found it to be an excellent anæsthetic, affording often prompt relief.

*Treatment of Diabetes.*—In a paper recently published (*Sitzungsberichte der Kais. Akad. d. Wiss. zu Wein*, Bd. lxvi. Heft iii iv. and v.), Dr. KRATSCHMER gives the results of a series of observations he has made on a diabetic patient, with a view of testing the value of carbonate and sulphate of soda, and of morphia, upon the excretion of sugar. He finds that neither the carbonate nor the sulphate appeared to exert any influence on the amount of sugar excreted, but he has satisfied himself that in morphia we possess an agent that is not only capable of materially reducing the excretion of sugar, but also of diminishing to a remarkable extent the general tissue metamorphosis of the body.—*Practitioner*, April, 1874.

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*Chloral Hydrate successfully used in Tetanus.*—Dr. CORYLLOS, of Patras in Greece, published a case of this kind in the *Allgem. Wiener Med. Zeit.*, No. 2, 1873, and now the same author records two similar cases, one under his own care, and the other treated by Dr. Basilin. The latter case relates to a woman of forty, who had wounded her finger with a splinter, which she removed herself. Tetanus occurred one month after the accident, and she had more than ten general attacks in the twenty-four hours. Sixteen days after the first tetanic symptoms the patient removed from the wound a bit of splinter, the size of a pea, which had been left in it unobserved. The usual narcotics having failed, chloral was tried and succeeded. Altogether three ounces and a half were taken in twenty days.

In Dr. Corylos' case a man of forty had his left temple wounded by a pointed piece of reed. Tetanus supervened, and here again, a portion of the foreign body was removed twelve days after the accident. He had at first fifteen-grain doses of chloral, and improved much upon them, but the tetanus recurred with renewed severity, and the chloral was pushed as far as 120 grains per diem. The patient completely recovered, and had taken, in about thirty days, six ounces of chloral. —*Lancet*, April 4, 1874.

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*Treatment of Syphilis.*—Mr. JONATHAN HUTCHINSON, in an article in a recent number of the *British Med. Journal* (Feb. 28, 1874), states that the object of his recent paper (see *Amer. Journ. of Med. Sci.*, April, 1874, p. 536) was rather to attract attention to the evidence in favour of the permanent efficacy of the mercurial treatment of syphilis in its early stages, than to advocate any special mode of its use. I was, however, led, he says, almost necessarily, in order to sustain my argument, to insist on the necessity for a long course, and, as a means in order to the practicability of long administration, on the avoidance of doses likely to cause salivation. I had to contend also that the antidotal power of the drug is in no degree of relationship to its full physiological influence; and that the best cures are often those made most quietly. Now, these principles being kept in view, I do not know that there is much to be added as to detail. Begin early; continue long; do not salivate—such would be my rules. I have no strong preference for one kind of mercurial preparation over another; but, as it is convenient to become familiar with one, I have in my own practice of late years almost restricted myself to gray powder. I prescribe it usually in pill, in doses from one to three grains three times a day, and often in combination with Dover's powder. It is only seldom that an unlooked-for salivation occurs, and it is equally rare to have any trouble with the bowels. Most of my patients continue throughout at their ordinary occupations. A strong reason for preferring to give pills, instead of using inunction or the bath, is, that it is often essential to avoid confinement to the house, and also to run no risk of attracting the attention of the family. Inunction, which is still in general use over the continent, and is without rival at Aix-la-Chapelle, is a more or less dirty method; can scarcely be concealed from servants; and further, with our English ointment, is very prone to irritate the skin and bring out eczema. As I do not believe that it has any real advantages to compensate for these drawbacks, I never resort to it. The vapour-bath, as proposed by Langston Parker and modified by Mr. Lee, I have the fullest faith in,

and have seen excellent results from it in certain intractable cases. It is, however, troublesome, more or less expensive, cannot well be used secretly, and, for all ordinary purposes, it is not in the least necessary. The gray powder does all that could possibly be wished. I must add to this, that I am always particular to use mercury sedulously to the local manifestations of the disease. The chancre is to be soaked with black wash; and to the skin-eruption an ointment of the ammonio-chloride is almost always applied. If the throat becomes sore, a gargle of black wash or of the bichloride is usually prescribed.

With regard to the dose, it ought to be sufficient to produce decided effect on the disease. If it be given for an indurated chancre, the hardness ought to begin to diminish within a week. The quantity required in order to effect this will be found, as every one knows, to vary very much in different individuals. A few patients will be met with who appear to resist mercury in a most extraordinary manner, in whom it neither destroys the syphilis nor affects the constitution. As a rough rule, I always expect to have to give more mercury to dark complexioned patients than to others.

Whether iodide of potassium is antidotal or not, it is very difficult to say; but I think we may take it as proved, that it is at best very feeble as an antagonist against the early stages of syphilis. It cannot make the indurated chancre disappear; and I think it does not usually shorten the duration of the secondary rash. A main object of my paper was to protest against its delusive employment in these stages, and to urge that it is false to our patients' interest to permit it to stand in competition with mercury, so far as they are concerned. Even in the case of the most feeble and cachectic patients, it is, I think, a mistake to resort to it, to the exclusion of mercury. But there is much respecting its powers which is yet to be made out. The rapidity and certainty with which it will cure some forms of tertiary disease are very wonderful; and from the inveteracy which these used to assume prior to its introduction, we may, I think, safely infer that the mercurial methods then in vogue were not successful. Of late years, mercury has been but very rarely tried for tertiary disease; and I for one may freely confess that I am not in possession of any large number of facts respecting it. Whether or not it might in certain cases cure more permanently than the iodide, I have no means of knowing; whilst that it would prove prejudicial in many is, I think, highly probable. Now, if the theory which I have advanced as regards the distinction between the secondary and tertiary maladies be true—that the former are due to blood-changes, and the latter to those of tissue—it possibly follows that we ought not to expect anything of the nature of prevention from the remedies which we use against the latter. It is enough if they cause the local inflammation to cease, and not possible that they should alter the constitution of the solid tissues, built up as they have been years ago, from a tainted blood. My impression is, that this conjectural view is supported by clinical experience, and that we do not find any benefit from continuing the iodide after the local cure has been completed.

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*Silicate of Soda in Venereal Affections.*—Sée (*Annales de Dermatologie et de Syphiligraphie*, 4me année, 1872-3) used a solution of silicate of soda, varying between one and three per cent of the salt in water, as an injection for urethral discharges or lotion for chancres, with or without phimosis. He experimented on twenty-five patients, and found that ill effects, orchitis, cystitis, bubo, etc., followed in none, however acute the stage of the disease; while, as a rule, the disorder was greatly shortened in duration, and in some was cured in a few days. Also, when used as a three per cent. lotion to phagedenic sores, it produced speedy improvement in their appearance; and in a case of chronic cystitis from lithic acid irritation, six injections cured the disease.—*London Medical Record*, Dec. 24, 1873.

*Local Anæsthesia at Point of Insertion of Aspirator.*—Dr. B. W. Richardson calls attention (*Lancet*, April 4, 1874) to a little practical point of value when ether spray is used for preventing the pain caused by the puncture of the needle. It is this: after freezing thoroughly over the space of a crown-piece, at the point where the puncture is to be made, place the point of the finger in the centre of the frozen part, and thaw at that point completely. When the skin at the spot under the finger is thus rendered quite yielding, the needle can be passed through it still painlessly, if the surrounding part be kept thoroughly frozen. Dr. R. acknowledges his indebtedness to Mr. W. Adams for this suggestion.

—

*The Propagation of Cholera.*—The official report of Dr. Hirsch, just published by the German Government, on the appearance and march of the cholera in the Prussian provinces of Posen and Prussia in 1873, supports the conclusions established by British and Indian observers, that the cholera is carried along the lines of human communication. The experience of late years has proved that the disease is imported almost regularly by the barks on the Vistula, the wood-rafts, and the cargoes of wheat. The author shows by a series of carefully investigated facts, that the cholera advanced into Posen and Prussia along the course which the wood-trains pursue, and followed in their track. He dwells upon the necessity of public hygiene.—*London Medical Record*, April 1, 1874.

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*Additional Method for removing Fibroids of the Uterus.*—P. Wallis (*Dorpater Medizinische Zeitschrift*, vol. iv. 1873) states that in two cases where he failed to remove the growths by the usual methods, he succeeded admirably by means of his hand, tearing through the attachments. Both cases did exceedingly well. The tumour in the one case was about the size of a man's fist; in the other a small soft fibroid.—*London Med. Record*, April 15, 1874.

*Cells in Ovarian Fluid.*—Dr. W. Mac-Ewen and Dr. R. Forrest, at a late meeting of the Glasgow Pathological and Clinical Society (*Brit. Med. Journ.*, March 28, 1874), showed specimens of ovarian fluid, and the former showed the microscopic cells supposed by Dr. Drysdale (Philadelphia) to be characteristic of ovarian tumors. Dr. Alex. Robertson and Dr. Joseph Coats said they had submitted these cells to careful examination, and to the test with ether, but had failed to verify Dr. Drysdale's statements on this subject.

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*Death from a poisonous dose of Hydrate of Chloral.*—An inquest has lately been held at Lincoln in England on the body of a woman, aged thirty-eight, who died from an overdose of hydrate of chloral. It appeared that she had been for some time past in the habit of taking various narcotics, and latterly had become a slave to chloral-drinking, which she took frequently and in large doses, as much as eighty grains at a time.—*Lancet*, April 11, 1874.

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*Death of an Infant from using an Acetate of Lead Lotion to the Nipples.*—M. Bouchut (*Gazette des Hôpitaux*, 1873) mentions a case where a lady had used a lotion called "Eau de Mad. Delacour," a favourite quack remedy in Paris for sore nipples. She had omitted to wash the lotion off before putting the child to the breast. It was seized with violent colic, and died in a few days with all the usual symptoms of lead poisoning.—*London Med. Record*, April 15, 1874.

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*The Writing of Ataxic Patients.*—At a recent meeting of the Biological Society of Paris, M. Onimus showed specimens of the handwriting of ataxic patients. They write in the same way as they walk, their writing presenting the characteristic irregularity and jerky abruptness. The letters are not rounded, the a's and o's being nothing but straight lines; whilst others have undefined terminations, such as the q's and the p's. At a more advanced stage, just as the foot strikes the ground

with violence, so the pen leans so heavily on the paper as to perforate it. Therefore, ataxic patients only use pencils.—*London Med. Record*, April 15, 1874.

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*Contamination of Aerated Waters.*—An eminent Fellow of the Royal Society communicates the following to the *British Medical Journal* (Feb. 14, 1874). Suspecting that lead might exist in potash-water contained in the ordinary siphon-bottles now generally in use, I placed six such bottles in the hands of Mr. Brownen, the expert chemist working in the laboratory of Messrs. Savory and Moore of Bond Street. I send herewith his report, and also results obtained from the examination of soda and of seltzer water contained in siphon-bottles.

It is highly important that this source of poisoning by lead should be made known, not only to the profession, but to the public.

Mr. Brownen presents the following report:—

Six siphon-bottles of potass-water, one of soda, and one of seltzer, were examined. All the samples contained lead. In two instances this metal was associated with zinc. The latter metal was identified by the white colour of its sulphide, its solubility with alkalies, and precipitation with potassium ferrocyanide. The proportion of lead in these bottles of water varied greatly, but in no case could it be estimated gravimetrically. The proportions were therefore estimated colourmetrically by comparison with a standard lead solution containing .1 of a *gramme* per *litre*, and precipitated by hydrogen sulphide from an acidified solution.

The following are the results obtained; the quantities stated being the amount of lead in a *litre*. No. 1 potassa-water, .012 *gramme;* No 2 ditto, .011 *gramme;* No. 3 ditto, .013 *gramme;* No. 4 ditto, .006 *gramme;* No. 5 ditto, .007 *gramme;* No. 6 ditto, .010 *gramme;* soda water, .0081 *gramme;* seltzer water, .012 *gramme*. As even carbonate of lead is somewhat soluble in carbonic acid water under pressure, it does not preserve the bottle, pewter cock, or luting from the well-known solvent action of alkaline salts on lead or zinc.

*Retirement of Professor Hyrtl.*—Dr. Hyrtl, the eminent Professor of Anatomy in the University of Vienna, delivered his final lecture on the 16th of March, and took leave of his class. In the afternoon, he met an assemblage of more than three thousand pupils and friends, who presented him with addresses and other expressions of esteem, which were feelingly acknowledged by him. During the day, more than fifty congratulatory telegrams were received from all parts of the world—Petersburg, Moscow, Paris, Philadelphia, London, New York, Constantinople, Berlin, Prague, Pesth, Cracow, and various other places in the Austro-Hungarian Empire, including Eisenstadt, Hyrtl's birthplace. The festivities of the occasion were prolonged to near midnight. On the following day, the Municipal Council of Vienna conferred honorary citizenship on him.—*Brit. Med. Journ.*, March 28, 1874.

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*Proposed Statue of the late Dr. Robert J. Graves.*—We take pleasure in calling attention to the subjoined circular, which has been sent to us, with the object, we presume, of inviting contributions for a statue of one who is well known in this country by his valuable contributions to clinical medicine, and who was one of the most eminent practitioners of his day.

Dublin, Merrion Square North,
December, 1873.

Dear Sir: A number of the friends, former pupils, and admirers of the late Dr. Robert J. Graves, residing in different parts of the kingdom, have agreed to form a committee for the purpose of receiving subscriptions for a statue, which, in accordance with a resolution of the College of Physicians, is to be placed in the hall of the College.

On behalf of the Committee we hope for your cordial co-operation and support in the endeavour to raise so well-deserved a memorial to this distinguished representative of the Irish School of Medicine.

Signed for the Committee.

William Stokes, A. Hudson, W. E. Wilde,

*Hon. Secretaries.*

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## CLINICS.

### CLINICAL LECTURES.

*Clinical Lecture on Fever.* Delivered at St. Thomas's Hospital. By THOMAS B. PEACOCK, M.D., Senior Physician to the Hospital.

GENTLEMEN: During the last few weeks several cases of fever have been under my care in this hospital upon which I propose to offer some remarks. Of these cases, three were cases of typhus and five of typhoid. Two of the cases of typhoid occurred in a mother and child. The mother was twenty-nine years of age, and was admitted into the hospital on the 28th of October, being then stated to have been ill for two weeks, but out of health some time longer. She had symptoms of low fever, a high temperature (103.6°), and much bronchitis; and was greatly prostrated. There were a few small, round, livid, non-fading spots about the upper part of the thorax and the lower part of the neck. The spots had disappeared on the 4th of November, or on the seventh day after her admission; but the feverish symptoms did not readily subside. The temperature continued high, and the prostration was so persistent that she was not able to leave her bed before Christmas day, or the fifty-eighth day from her admission into the hospital; and she was not presented before the 4th February, or the ninety-ninth day from admission. The case was very obscure; but it was thought most probable that it was a case of typhus, which had passed its acme before it was admitted; but if so, the commencement

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of convalescence was imperfectly marked, and the duration of the attack was very much prolonged. The protracted convalescence might, however, it was thought, be due to the severe bronchitis with which the attack was complicated, and to the patient having been for some time before the occurrence of the severe illness very much out of health. At the end of November, however, we heard, what had been before denied, that there were other members of the family ill at home; and Mr. Donkin, the house-physician, went down to Greenwich, where the patient resided, and found one child convalescent from some form of fever; and another, eight years of age, seriously ill. This child was removed to the hospital on the 28th of November, the report then being that it had been ailing for about a month, but seriously ill for two weeks. The child had symptoms of active fever, a temperature of 104°, and severe bronchitis. There was a copious eruption on the trunk, very similar in appearance to that which had been observed on the mother. The child became much prostrated, and made a very gradual and slow recovery. She was not able to leave her bed before the 6th of January, or the thirty-ninth day from the period of admission; and was only presented on the 4th of February, or the sixty-eighth day from her admission into the hospital. There could be no doubt that the child's case was one of typhus, and that confirmed the correctness of the diagnosis in the case of the mother.

In the third case of typhus the patient was a boy, thirteen years of age, admitted on January 1st. At that time he was stated to have been ill eleven days. There was a copious eruption of livid spots on the skin, and symptoms of high fever, the temperature being 104.6°. The spots disappeared in two or three days, and on January 8th the temperature fell to 98.6°, and from this time he made a rapid recovery, being able to leave his bed on the 13th. He was discharged on the 27th, or the thirty-eighth day from the stated period of the commencement of the symptoms. In this case the nature of the disease was quite clear, and the case followed the course which it generally does in children. The diagnosis was further confirmed by the admission a few days after of a brother of the same patient, also presenting symptoms of typhus.

The cases of typhoid to which I refer were five in number. Of these, the first was that of a boy, aged twelve, admitted on the 4th of October, having been then ill for two weeks, but out of health for two or three months before. He had diarrhœa before he was admitted, but was not so seriously ill as to be confined to bed. On the day of admission he had a high temperature, 103.7°, and was considerably prostrated; the diarrhœa continued, and the evacuations were passed in bed. The symptoms of fever were severe and protracted, the diarrhœa very persistent. He was constantly delirious, and subsequently became very torpid and difficult to arouse. There were never any spots upon the skin. The attack was very prolonged, so that the convalescence was not established before the 16th of December, or the seventy-third day from admission, and he was not discharged before the 8th of January, or the ninety-sixth day from admission. During a large portion of his convalescence he was excessively fractious and difficult to manage.

The second case occurred in a female, twenty-one years of age, who was received into the hospital on the 8th of October, having been then ill for four days. In this case, though the fever was severe, the temperature rising to 105°, the chief symptom was prostration of strength, there being neither spots on the skin nor diarrhœa, and not very marked cerebral disturbance. There could, however, be no doubt that there was considerable intestinal disease; for even when convalescence was apparently fully established, a very small dose of castor oil, given after there had been no evacuation from the bowels for several days, was followed by frequent loose evacuations and a sharp recurrence of fever, which, however, subsided in two or three days. She was convalescent on the 28th of October, or the twentieth day

from admission, and the twenty-fourth from the reported time of seizure; and she was discharged on the 19th of November, or the forty-second day from admission.

The third case of typhoid occurred in a probationer nurse at the hospital, twenty-five years of age. She had been in attendance on two cases of typhoid, in both of which there was diarrhœa, and in one the evacuations were passed in bed. Her attendance on these cases commenced about three weeks before her admission into the ward, and ceased about a week before; after which time she was employed in watching a surgical case in which there was a profuse and offensive discharge. About the same time she became poorly, and after four days she was so ill, suffering from diarrhœa and feverish symptoms, as to be incapable of attending to her duties. On the 14th October, or the fourth day of serious illness, she was admitted into the ward. During the remainder of the attack she had no diarrhœa; indeed, evacuations were only procured by the employment of medicine. There were, however, spots coming out at the time she first came under care, and they continued to appear for ten days. Her temperature was high (103.8°), and she was much prostrated. She became convalescent on the 11th November, or the twenty-eighth day from her admission into the ward and the thirty-first from the commencement of serious illness; and she was discharged on the 11th December, or the fifty-eighth day from admission.

The fourth case was admitted during protracted convalescence. The patient was a girl aged fourteen, who was admitted on the 12th December, and was stated to have suffered from symptoms of typhoid for four months, without ever having become satisfactorily convalescent. She was excessively fractious and impracticable; had a very dry, harsh skin, a high temperature (103.2°), and hectic symptoms. The bowels were confined. Under the use of baths and the inunction of oil, the skin became moist and the symptoms subsided; and she was convalescent on January 6th, or the twenty-fifth day from admission, and was discharged on the 26th of the same month.

The fifth and last case was a very obscure one. The subject of the disease was a young man aged sixteen, employed as a clerk, but who had recently been leading a somewhat dissipated life. He was admitted on the 22d of December, and was then stated to have been ill for four days. He had symptoms of active fever, and was delirious, and two days after admission became so violent as to require restraint. In two or three days he was quieter, but not entirely free from delirium. Before his admission he had not had any diarrhœa, but four days after the bowels became much relaxed, and he passed the evacuations in bed. The abdomen also became excessively tender and tumid, and the temperature rose to 103.6°. The breathing was rapid, and he died exhausted on the 8th January, or the seventeenth day from the time of admission, and the twenty-first day from the reported period of the commencement of illness. There were not any spots at any time on the skin. On examination after death there was found general peritonitis, and a perforation of the ileum had occurred at a point between two and three feet above the cæcum. The mucous membrane was free from disease everywhere except at the seat of perforation and immediately above the ileo-cæcal valve. At the latter point two of the plates of Peyer were very distinct, and the mucous membrane above and around them was slightly reddened and somewhat abraded. As I have before said, the nature of this case was not obvious, but it seems most probable that it is to be regarded as one of typhoid. Except some little pneumonic exudation, there were no morbid conditions found in the body, except those in connection with the alimentary canal; and though the intestinal disease was, except at the point of perforation, very slight, it is well known that in typhoid there is often no correspondence in intensity between the amount of mischief in the bowel and the degree of constitutional disturbance. Occasionally also the perforation occurs in cases in which there is very little in-

testinal disease. Indeed, Chomel has recorded in his "Clinique Médicale" a case which is almost the counterpart of this.

The first remark which I have to make in reference to these cases is as to the diagnosis—that it is impossible to distinguish between typhus and typhoid from one or two symptoms, however important such symptoms may be, but that to ascertain the nature of each case we must take into consideration the whole history of the disease, its mode of origin, its course, the symptoms by which it is characterized, and the mode in which the febrile symptoms subside. A case of typhus usually commences suddenly and rapidly progresses, so that the patient is admitted into hospital at an early period, generally before the seventh or eighth day; and usually also the case undergoes a marked amendment, if there be not any serious local complication, about the fourteenth day. Yet it will be observed that in two of the three cases to which I have referred the time of commencement of the symptoms could not be distinctly ascertained, but the patient had certainly been ill for an unusually long time when admitted. Indeed, in both the eruption had certainly been on the skin for several days when the patient was first seen, and was clearly passing away in the first case. In both of them the period of convalescence was very imperfectly marked, the amendment was very gradual, and the whole attack unusually prolonged. In the third case, though the time of seizure was more clearly ascertained, the period of admission was also unusually late, but the case followed the usual course, and the time of commencement of convalescence was well marked, and the progress to recovery was rapid. It is not uncommon to hear a case pronounced to be typhus because it is characterized by marked symptoms of cerebral disturbance and absence of abdominal disorder, or to be typhoid because the abdominal symptoms are predominant, and there is comparatively little cerebral disorder. But nothing can be less to be depended upon than these symptoms as indicating the several forms of disease, and it not very unfrequently happens that cases confirmatory of this remark are in the hospital at the same time. This was the case some time ago. In one case a middle-aged female was admitted, after a few days' illness, with symptoms of fever, much prostration of strength, and profuse diarrhœa, but there was not any marked cerebral disorder, and she passed favourably through the attack, the diarrhœa ceased, and in about twenty-one days she was convalescent. Judging from the presence of diarrhœa and the absence of marked cerebral disorder, the case might have been supposed to be one of typhoid, but it was really, as indicated by the general symptoms and the eruption on the skin, one of typhus. In the other case a young man was admitted after an obscure indisposition of three weeks' duration, with symptoms of cerebral disturbance, but without diarrhœa or other evidence of abdominal disorder. This case might therefore have readily been mistaken for one of typhus, though in reality typhoid, the diagnosis being established by the appearance of the usual rose rash. Severe cerebral symptoms indeed very frequently occur in the early stage of typhoid, while diarrhœa is occasionally absent. The latter was the case in two out of the five cases referred to, though in one of them the bowels had been relaxed before the patient came under notice, and in the other the tendency to intestinal disorder was indicated by the undue action of a small dose of mild aperient, even when convalescence appeared well established. The eruptions on the skin, differing as they do in the two forms of fever in the periods at which they make their appearance, the forms which they assume, and the course which they follow, were they of invariable occurrence, would afford a ready and conclusive means of establishing the diagnosis. But though the eruption probably occurs at some period of the attack in all cases of decided typhus, the spots in typhoid are very uncertain, being often absent in cases of otherwise well-marked typhoid. I find that in only thirty-seven out of forty-four fully reported cases of typhoid which have recently occurred, were there any spots on the skin; and it will be re-

collected that they were absent in two of the cases of which I have spoken—one of them being the most severe of the five cases, and the other a decided though not very severe case.

I have a few remarks to make in reference to the treatment of cases of fever. We are all agreed as to the importance of carefully regulating the diet of a patient in the active stages of the disease, and of rigidly enforcing his being kept in bed; but I doubt whether, in typhoid more especially, the importance of continuing the same precautions sufficiently long during convalescence is generally realized. The frequency with which relapses occur in typhoid is a peculiar feature of the disease, and probably they cannot be entirely prevented; but I believe they generally result from the patient being allowed to indulge his appetite too freely, or to leave the bed too soon; and I think that the very small proportion of relapses that have recently occurred in my cases—only two in sixty-five—has been mainly due to the unceasing care which I have taken to prevent either of these mistakes being committed. Probably the cessation of the symptoms of active fever indicates the period at which the mischief in the alimentary canal ceases to progress, but after this the ulcers take a long time to heal. I have known a patient die on the eightieth day, and the ulcers to be still not entirely healed. During the time that there are any remains of ulceration it is most important that the bowel should be kept as quiet as possible, and the patient be persistently fed on the lightest and most easily assimilable food, so that no accumulation may take place. For the same reason the food should be given only in small quantities, and at regular intervals. These rules I steadily enforce, however long may be the duration of the attack, while the tongue still continues furred, and there is any diarrhœa, or tenderness or inflation of the abdomen; and I confine the patient to bed, or at least to the recumbent position, till he has recovered considerable strength. I have known a patient die of perforation when he had apparently so completely recovered as to be allowed to leave the hospital, the untoward event having been caused by his indulging too freely in food, perhaps not of a digestible character. It is also of great importance to avoid exposure to cold during convalescence; for patients in the weakly state, which after severe typhoid is so very persistent, are very susceptible to cold, and readily suffer from bronchitis or pneumonia. All excitement of mind should also be avoided. I have known a patient, from neglect of proper care in this respect, suffer from acute and fatal cerebral inflammation when he seemed to have almost completely recovered.

There is some difference of opinion among practical men as to whether it is better at once to restrain the diarrhœa in typhoid, or to leave it alone unless very severe. In the early stages of typhoid there is usually diarrhœa. As the case progresses the stools generally become less frequent and more consistent; and towards the end of the attack the bowels are usually confined, and sometimes very obstinately so. This would appear to indicate that the right line of practice is to leave the case alone, unless the diarrhœa be so severe as to imperil the safety of the patient, in which case it should, if possible, be checked. I, however, while refraining from giving astringents in cases of ordinary typhoid, regard the frequency of the evacuations as in part indicating the amount of stimulus and support which should be given to the patient, and I believe that this rule will generally be found to answer.

When in cases of typhoid the bowels become confined, much caution is required in the exhibition of aperients; enemata are always safe, and generally will procure sufficient relief; but sometimes, and especially when the patient is taking a fair amount of food, more free evacuation may seem to be required; and yet the mildest aperients may bring back the diarrhœa and cause a relapse. The rule which I generally follow is not to interfere so long as the patient is apparently not suffering from the bowels not being acted upon, and this even though several days should elapse; but if the patient complains much of the sense of fulness,

or experiences uneasiness or pain, and especially if the abdomen becomes tumid and tender, the bowels must be relieved. Under these circumstances I generally order a dose of calomel and opium, one or two grains of the former to one of the latter, and follow this by a small dose of castor oil, and by an enema if necessary, and the effect of one or two doses of this kind is almost always to procure full and satisfactory evacuation, after which the symptoms generally entirely subside. You will recollect that in the case of the nurse the bowels were not acted upon for six days, at the end of which time threatening symptoms appeared, but entirely subsided under the course of treatment which I have mentioned. Similar symptoms also occasionally occur during even advanced convalescence from too much food, or food of an improper kind being taken, and they are best treated in the way I have stated.

The last remark which I have to make is in reference to the employment of stimulants in the treatment of fevers. Some years ago, under the influence of teaching which I cannot but regard as mistaken, stimulants were so largely given in fever and other forms of active disease as to constitute almost the whole treatment, and make it often difficult to decide, when patients were seen, how much of their condition was due to the disease under which they laboured, and how much to the treatment employed. Now, however, a more judicious system is followed, and stimulants are less constantly and freely given. But there seems danger that, in the reaction, the discontinuance of the use of stimulants should be carried too far. Believing, as I do, that the abuse of fermented beverages is the greatest social bane in this country, I should have been glad could I conscientiously have done so, to have recommended the entire abandonment of the use of stimulants in the treatment of fever and other forms of disease. To do so would, however, I believe, be to deprive ourselves of one of the greatest means of alleviation which we possess, though one which requires great care in its use. It would be very much more satisfactory if the employment of these and other remedies could be reduced to some definite and scientific rules; and endeavours have been made by the careful analysis of the results of different methods of treatment to deduce such general rules. But the cases which we have to treat are so variable in their character that it is impossible so to classify them as to be sure that the cases compared are really similar, and that the results obtained are to be depended upon as exact. I fear, therefore, that we must be content still to leave to the judicious physician the choice of the means of treatment to be pursued in any given case, guided by his knowledge of the disease he has to treat, and his experience of the results of the means employed in other similar cases. So far as the use of stimulants is concerned in the treatment of fever, it is impossible to lay down any general rules; but I believe them to be eminently beneficial when given when the active stage of disease is subsiding, and the patient's power is beginning to give way, with the view of upholding the strength while the disease is in process of cure. If the patient is much prostrated, and the pulse weak, intermittent, or irregular, or abnormally slow, they may confidently be given; and if under their use the patient becomes less restless, the pulse improves in character, and the prostration diminishes, they may safely be persevered with. The amount of stimulus which is required must also be left to the discretion of the practitioner; but generally it is more advantageous if exhibited in small doses, repeated when the effect begins to subside. If a given dose exhibited at certain stated intervals seems to excite the patient, it does not follow that no stimulant is required; it may rather be that the dose is too large, and the repetition too frequent. When the patient's strength becomes greatly exhausted, as it often does when the crisis of the disease is passing or passed, the very liberal exhibition of stimulants may be necessary; and as the weakness becomes less and more food is taken, the

quantity may be gradually lessened; but I think it is a great mistake to suppose that because the patient can be got to take a large quantity of food, the use of stimulants is unnecessary. Food, as I have before said, may easily be given too freely. The best results ensue from the judicious combination of moderate amounts of food and stimulus, and this is especially the case at the period of early convalescence. In estimating also the desirableness of administering stimulants in any given case, the question to be asked is not simply whether the patient will recover without their use, but whether he will make an equally good and rapid recovery without them. Typhus and typhoid are diseases of very variable severity, and this is especially the case with typhoid, and there are some cases of both forms which will do very well without any stimulant at all. But, on the other hand, I have not unfrequently seen, in cases of fever which have never been very severe, that the patient will go on from day to day without making any material progress so long as stimulants are withheld, while on the exhibition of a small amount of wine or spirit there has been a marked and quite unmistakable improvement in the condition of the patient, and the case has afterwards steadily progressed to recovery. What I would wish to impress upon you is, not that you should make up your minds to give or not to give stimulants in cases of fever, but that you should hold yourselves free to have recourse to them, or not to use them, according to the apparent requirements of the several cases which you have to treat. There can be no worse fault in medical practice than to adopt a hard-and-fast rule as to the plans of treatment or special remedies to be employed in any form of disease. You should endeavour to make yourselves fully acquainted with the nature of the disease you have to treat and the condition of your patient, and then prescribe the course of treatment which you think will most conduce to his recovery.—*Lancet*, March 28, 1874.

## HOSPITAL NOTES AND GLEANINGS.

*Traumatic Aneurism of the Femoral Artery; Digital Compression for Ninety Minutes; Cure.* Under the care of Mr. F. R. P. Drake, at the Salisbury Infirmary.

The following case is of interest, as showing the value of compression in the treatment of femoral aneurism. Ligature of the common femoral artery for femoral aneurism has not hitherto been attended by favourable results—in fact, some surgeons think that the operation should be banished from surgical practice. The satisfactory results in the present instance were no doubt greatly favoured by the nature of the aneurism and by the roughened condition of the interior of the vessels from degenerative changes, so that extensive surfaces existed favourable to the coagulation of fibrin.

C. P——, aged seventy-eight, was admitted on August 2, 1873. He states that about a month prior to his admission he received a kick from a horse on the right thigh, that the part turned black, but was not very painful, and that about a week intervened between the receipt of the blow and the appearance of the swelling.

On admission, the man was old and feeble, and had diseased arteries, the brachial artery, which was plainly visible at the bend of the elbow, being also tortuous and irregular. There was no abnormal cardiac dulness or distinct murmur over the region of the heart, but there was slight arcus senilis. In the epigastric region was a pulsating tumour, rather tender on pressure. He complains of pain in the right thigh extending down the calf of the leg, and on examining this part a pulsating tumour, as large as a moderate-sized orange, was seen at about the junction of the upper and middle thirds of the limb, six inches below Poupart's ligament. It was most prominent anteriorly, where it formed a globular swelling, and on placing the hand on this swelling, a most distinct thrill was experienced. On stethoscopic examination, a blowing murmur was distinctly heard, and pressure on the artery above con-

trolled all pulsation. The skin over the tumour was not discoloured, but very tense, whilst the limb at the seat of the swelling measured 19½ inches in circumference, being an excess of 3 inches over that of the opposite thigh, where the circumferential dimension was only 16½ inches.

From the age of the patient and the diseased condition of his arterial system, the case was not a promising one, and it was determined to try digital compression. This was commenced under the direction of Mr. Biggs, the house-surgeon, assisted by the Superintendent of Nurses, who kept up the pressure alternately, on the 3d of August last, at 3 o'clock P. M., the point selected being where the vessel issues from the pelvis. After the space of an hour the tumour became harder and less pulsating, and after the further lapse of half an hour (*i. e.*, ninety minutes in all) pulsation entirely ceased. The compression was then discontinued, and the limb covered with cotton-wool and bandaged.

*August* 4. Passed a comfortable night, complaining merely of slight pain down the thigh, which does not appear to be due to the tightness of the bandage. There is no return of pulsation in the tumour, which seems lessened in size, but hot. The circumference of the limb is 19⅛ in., but the toes of this foot feel colder than those of the other.

From this date the patient progressed favourably; the tumour became harder, and the limb decreased in dimensions. On his discharge from the infirmary, Sept. 13th, the limb gave a circumferential measurement of 16¾ in. The tumour was again examined on Sept. 16th, but no return of pulsation was to be found.

The point of interest in this case is the very short time (ninety minutes) that it was necessary to keep up the compression of the vessel. It is probably the shortest time on record in a case of femoral aneurism.—*Lancet*, April 25, 1874.

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*Cases of Malignant Onychia treated with Nitrate of Lead.*—Three cases of onychia maligna have lately presented themselves at the Charing Cross Hospital, which have all been treated by Mr. Fairlie Clarke with nitrate of lead, according to the suggestion of Mr. MacCormac.

The first patient was a traveller, aged forty-one, who had malignant onychia of the right little toe. The disease was of ten or eleven weeks' standing. The toe was much enlarged and clubbed, the nail was almost entirely gone, and there was an ulcerated surface the size of a threepenny-piece. There was severe pain, not merely in the seat of disease, but also in the ankle; and as the patient was obliged by his occupation to be constantly on his feet, it was a very serious inconvenience to him. He came to the hospital on December 28, 1873. The nitrate of lead was dusted on the ulcer, and he was told to apply it in a similar way every night and morning. He abstained from work for a week, and rested at home, so that he gave himself every chance. On the 19th the following note was made: "The toe is easier than it has been for a long time past. There is now a hard dry scab on the spot which was before raw and ulcerated." The patient continued to attend the hospital for a week or two longer, the onychia meanwhile slowly improving, and then he was lost sight of. After the lapse of four months he was met walking briskly along the street, following his ordinary occupation. He said that the nitrate had "effected a perfect cure" He had used nothing else, except "a lotion of herbs," and he had got speedily well.

The second case was that of a pale, flabby little boy, aged three years and a half, who was brought on January 20, 1874, with malignant onychia of the right thumb. The disease began a month before he came to the hospital, and took its origin from jamming the thumb in a cab door. The thumb had a very characteristic appearance, being enlarged through its whole extent, and clubbed at the point. The nail was ragged and misshapen, and the ulcerated surface around it bled freely. The patient was ordered steel wine, and nitrate of lead was dusted upon the sore night and morning. It was said at first that the application gave great

pain, so that the child screamed violently; and probably it was not applied regularly. Still the ulceration improved. At a subsequent visit the mother said that the application was less painful, and she asserted that it was regularly used. The case was steadily improving during the three or four weeks that he attended, but afterwards the child was attacked by the measles, and did not visit the hospital. The nitrate was, however, beneficial in this case, and would doubtless have effected a cure if it had had a fair chance.

The third case was that of a married woman, aged thirty-seven, who applied at the hospital on February 3, 1874. She was suckling at the time, and was rather weak. The malignant onychia had originated in the prick of a hair-pin two months before. When first seen the right thumb was red, swollen, and clubbed. There was a large, ragged ulceration; the nail had perished; and the last phalanx was necrosed, and was separating. She was ordered to take quinia mixture, and to apply the nitrate of lead twice a day. It gave her very trifling pain, and seemed to produce an immediate amendment. In a few days the last phalanx came away. As there was a good deal of pain in the thumb, poultices were applied over the nitrate. She went on steadily improving, without a drawback, and in six weeks the disease was cured, the thumb remaining of course somewhat misshapen in consequence of the loss of the phalanx.

On the whole, having regard to the severity of onychia maligna, and the great difficulty of treating it successfully by the ordinary lotions or ointments, Mr. Fairlie Clarke is inclined to think that the remedy to which Mr. MacCormac has drawn attention is a very valuable one.—*Lancet*, May 23, 1874.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Twenty-seventh Annual Meeting of the American Medical Association.*—The twenty-seventh annual meeting of the American Medical Association was held in the city of Detroit, June 2, 3, 4, and 5, 1874; 427 members were in attendance.

The Association was called to order by the President, Dr. J. M. Toner, of Washington, D. C. After prayer by the Right Rev. Samuel A. McCoskry, Bishop of Mich., Dr. Wm. Brodie, Chairman of the Committee of Arrangements, welcomed the delegates. The President then delivered his annual address.

Dr. Parvin, of Ind., moved that the recommendations contained in the President's Address be referred to a committee consisting of Drs. White, of N. Y., J. D. Jackson, of Ky., Bartlett, of Wis., Shippen, of U. S. N., and Westmoreland, of Ga. Carried.

*June* 3. The appointment of the Committee on Nominations was announced.

Dr. N. S. Davis, of Ill., presented the report of the Judicial Council, in reference to the revision of the Code of Ethics. "After carefully reviewing the whole subject," the Committee "do not recommend any alteration in the present Code of Ethics." The report was unanimously adopted.

The following amendments to the plan of organization were adopted.

Strike out the second paragraph of Article II., and insert the following:—

"The delegates shall receive their appointment from permanently organized State medical societies, and such county and district medical societies as are recognized by representation in their respective State societies, and from the medical department of the army and navy of the United States."

Also, strike out the fourth paragraph of same article, and insert:—

"Each State, county, and district medical society, entitled to representation, shall have the privilege of sending to the Association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number. Provided, however, that the number of the delegates from any particular State, Territory, county, city, or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the code of ethics of this Association.

"The medical staff of the army and navy shall be entitled to four delegates each."

Dr. J. M. Keller, of Ky., presented the report of the Committee on Rank of the Medical Staff of the Army, which contained the following preamble and resolution:—

*Whereas*, We have learned with regret that Congress has not as yet acted favourably on our memorial in behalf of the medical corps of the army; and whereas it is in our opinion just and right that the rank of the medical officers of the army should be fully equal to that of the officers of the other staff corps, or of the medical corps of the navy, which we are informed is not the case under existing laws; therefore,

*Resolved*, That a committee of one from each State and Territory, with power to fill vacancies, be appointed for the purpose of memorializing Congress on this subject, and of securing the co-operation of the several State and county medical societies for the same purpose.

Dr. Woodward, of U. S. A., offered the following additional resolution:—

*Resolved*, That Dr. J. M. Toner, of the District of Columbia, be chairman of said committee, and that the other members of the committee be appointed by the President.

The above were unanimously adopted.

Dr. N. S. Davis, of Ill., delivered the Annual Address upon Practical Medicine.

Dr. S. D. Gross, of Pa., delivered the Annual Address upon Surgery.

*June* 6. Dr. White, of N. Y., on behalf of the Committee on President's Address, reported that the Committee concurred in the view expressed by the President in his Address, and offered the following resolution:—

*Resolved*, That the President appoint a committee of five, of which he shall be chairman, to elaborate a plan for the organization of an International Medical Congress, and report at the next meeting.

The report was accepted.

Resolutions in regard to the death of Dr. Henry Miller, of Ky., were read and adopted.

Dr. Keller, of Ky., offered the following:—

*Whereas*, A most laudable effort has recently originated in the Boyle County Medical Society, of the State of Kentucky, and in the Kentucky State Medical Society, to create a fund for the erecting of a statue or some other suitable memorial in honour of Dr. Ephraim McDowell, "the father of ovariotomy," English writers to the contrary notwithstanding, who lived in the town of Danville, in the State of Kentucky, and who performed in that town the first ovariotomy, in the year 1809:

*Resolved*, That the American Medical Association most earnestly endorse the action of said County and State Societies, and as urgently commend the object to the generous consideration of the medical profession of the world. Adopted.

Dr. Parvin, of Ind., delivered the address on Midwifery, and Dr. A. N. Bell, of N. Y., that on Hygiene.

Dr. Woodward, of the U. S. A., from the Committee on Nomenclature, reported progress.

*June* 5. On motion, the following gentlemen were appointed a committee to digest a plan for an International Medical Association: Drs. J. M. Toner, of D. C.; N. S. Davis, of Ill.; Alfred Stillé, of Pa., Austin Flint, of N. Y., and J. S. Billings, U. S. A.

Dr. Byford, of Colorado, presented the following report of the Committee on Nominations, which was adopted:—

*President*, W. K. Bowling, M.D., of Tenn. *Vice Presidents:* 1. Dr. William Brodie, of Mich.; 2. J. J. Woodward, of U. S. A.; 3. H. W. Brown, of Texas; 4. H. D. Didama, of N. Y. *Treasurer*, Dr. Caspar Wister, of Pa. *Librarian*, Dr. William Lee, of D. C. *Committee of Arrangements:* Drs. Edward Richardson, Lawrence Smith, Robert Gale, James Holland, Henry Bullitt, J. M. Keller, D. W. Yandell, Lewis Rogers, R. C. Hewett, all of Louisville.

Next place of meeting, Louisville, Kentucky. Time of meeting, first Tuesday in May, 1875.

*Chairmen of Sections:* Practice of Medicine, Austin Flint, M.D., of New York; Obstetrics, W. H. Byford, M.D., of Ill.; Surgery and Anatomy, E. M. Moore,

M.D., of N. Y.; Medical Jurisprudence, Jerome Cochran, M.D., of Alabama; Hygiene, H. I. Bowditch, M.D., of Mass.

*Judicial Council*, Drs. J. K. Bartlett, of Wis.; R. H. Gale, of Ky.; J. B. Johnson, of Miss.; J. R. Bronson, of Mass.; B. H. Catlin, of Conn.; Franklin Staples, of Minn.; W. T. Briggs, of Tenn., in place of the seven whose terms expire this year. Dr. A. N. Talley, of South Carolina, for two years, to fill vacancy.

Dr. Keller, of Ky., offered the following resolution, which was adopted:—

*Resolved*, That, in furtherance of the views expressed by Dr. Gross in his valuable address touching a proper legislation to prevent the spread of syphilis, a committee composed of Dr. Gross, of Pa.; Dr. N. S. Davis, of Ill.; Dr. J. M. Toner, of D. C.; Dr. Marion Sims, of N. Y.; and Dr. John Morris, of Ind.; be appointed to report at the next meeting the most feasible plan for securing such legislation.

The meetings of the Sections seem to have been of more than usual interest.

—

*Deaths from Chloroform.*—On the 18th of May, Dr. Jas. H. Butler, of Baltimore, attempted the reduction of a dislocated left shoulder in a man aged 48 years. A teaspoonful of Squibb's chloroform was administered on a napkin, and the operation was begun. In ten minutes a violent spasm came on, the patient's face became red, his eyes fixed, his lips were drawn up, respiration and pulse stopped. The spasm lasted but a short time, and then the patient died. Efforts at resuscitation were of no avail. No *post-mortem* examination was allowed.

In the *Clinic* for May 23, is recorded another case which occurred on the 19th of May, at the Good Samaritan Hospital in Cincinnati. The patient, a young man, was being operated upon by Drs. Dawson and Conner, for the removal of a scrofulous tumour of the groin. The chloroform was administered by one of the house physicians, when suddenly pulse and respiration ceased. Artificial respiration did not elicit a response.

—

*Painless Method of Cauterizing with Nitric Acid.*—It is found at the Charity Hospital, New York (*New York Med. Journ.*, May, 1874), that chancroids can be cauterized with nitric acid without causing severe pain, by first applying to the sore pure carbolic acid. The carbolic acid serves as a local anæsthetic, and prevents the nitric acid from causing pain which is not easily borne by the patient.

—

*Composition of Sage's Catarrh Remedy.*—Adrien Bowers, L. P., as the result of analysis, publishes (*Am. Journ. of Pharm.*, June, 1874) the following as the probable formula for this nostrum, which is extensively manufactured in Buffalo, N. Y.:—

Hydrastis canadensis gr. v.; Indigo gr. ss.; camphoræ pulv. acidi carbolici, āā gr. ij; sodii chloridi gr. l.

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*Medical Graduates in* 1874—*continued from page* 75.—

| | |
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*Hospital of the University of Pennsylvania.*—The Hospital building erected on the University grounds in West Philadelphia was inaugurated on June 4th, by the Governor of the State, in the presence of the Professors and Alumni of the University, and a large number of distinguished citizens.

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*Bellevue Hospital Medical College.*—Prof. D. Warren Brickell, M.D., has resigned the chair of Obstetrics and Diseases of Women and Children in this institution.

Prof. Edmund R. Peaslee has been elected Professor of Gynæcology.

—

*University of the City of New York.*—Dr. Stephen Smith has been appointed Professor of Clinical Surgery and Surgical Jurisprudence in the Medical Department of the University of the City of New York.

—

Obituary Record.—Died in New York, April 28th, aged 65 years, John H. Griscom, M.D., late Physician to the New York Hospital and formerly Professor of Chemistry in the New York College of Pharmacy.

Dr. Griscom was a graduate of the University of Pennsylvania, the author of

a number of medical essays, and a prominent and esteemed practitioner of medicine.

——— in Cincinnati, June 5, in the sixty-first year of his age, GEORGE MENDENHALL, M.D., formerly Prof. of Midwifery in the Miami Medical College, and one of the oldest practitioners of medicine in Cincinnati.

Dr. Mendenhall was President of the American Medical Association in 1870, and in 1872 was elected a Fellow of the Obstetrical Society of London.

## FOREIGN INTELLIGENCE.

*Notes of two Cases of Hemorrhagic Diathesis.*—Mr. CHARLES HIGGENS, Assistant Ophthalmic Surgeon to Guy's Hospital, reported to the Royal Medical and Chirurgical Society (*Lancet*, May 23, 1874) the cases of two brothers, the subjects of hæmophilia. The family history furnished a good illustration of the mode of transmission of the disease from the maternal grandfather through his daughter, who was not a bleeder, to five males of a family consisting of seven boys and one girl—the girl, as is the rule, being one of the exceptions. It also appeared that hæmophilia, although often fatal, does not of necessity shorten life, as the grandfather above mentioned lived to the age of eighty-six and died of old age. Another point of interest was the firmness with which the blood coagulated; in each of the cases reported well-formed clots were produced, showing that the hemorrhage was not due to want of coagulability.

Dr. Williams thought that if a chemical analysis of the blood was made it might throw some light upon the affection.

Mr. Sedgwick said that early observations tended to prove there was no difference of structure of the small bloodvessels. In three published observations thinning of the arterial walls was met with. German observers said it was not due to structural peculiarities of the vessels. He thought it would be well to examine the vessels in case of death. The study of the family history would show that the vessels, not the blood, were at fault. There was a tendency to outgrow the affection after a certain age.

Dr. Wickham Legg said that the chief feature in the natural history of the disease was its hereditary character. A singular case had been lately brought under his notice, where the hemorrhagic tendency could be traced back in the family as far as 1740; in the same village there were many families in which the boys bled from the bowels or the kidneys. The blood had been analyzed in Germany, but it was not found to differ from the normal standard. He believed the affection depended upon some change in the bloodvessels.

—

*On Œdema of the Left Upper Extremity in Heart Disease.*—M. HANOT draws attention (*Gaz. Méd. de Paris*, Février, 1874) to a fact which he has established in the case of several instances of cardiac valvular disease inducing general anasarca, and one which may be deserving of the attention of clinical observers, viz., the earlier and more rapid development, and greater extent and persistency of œdema of the left upper extremity, than of the right in these cases. He suggests an explanation as supplied by the comparative anatomy of the brachio-cephalic veins of the two sides, the longer and more oblique course of that on the left side causing, even in the normal state, a greater impediment to the return to the heart of the blood from the left than from the right arm.—*Irish Hospital Gaz.*, May 1, 1874.

—

*Ovariotomy.*—At the Hospital for Women, Soho Square, there were performed in 1873, 12 ovariotomies with 5 deaths, a mortality of 41.6 per cent. From 1865 to the end of the year 1871, 71 ovariotomies have been performed in that hospital with 27 fatal cases, or a mortality of 38 per cent.—*Lancet*, May 16th, 1874.

—

*Treatment of Cholera by the Hypodermic Injection of Chloral Hydrate.*—The supplement to the official *Gazette of India* contains a report from the civil surgeon, Kheri, in Oudh, with copies of communications from Dr Hall and the Deputy Surgeon-General Indian Medical Service,

Lucknow Circle, on the treatment of cholera by the hypodermic injection of chloral hydrate. It appears that Dr. Hall, in a paper published in the *Indian Annals of Medical Science* for March, 1870, stated that in the cold stage of cholera, instead of exhaustion of the nervous system, as was generally supposed, there is intense irritation of certain sets of nerves. He suggested that the principle which should guide us in the treatment of this condition was the endeavour to quiet the nervous system by the action of pure sedatives, and recommended the practice of hypodermic injection of sedatives in the stage of collapse. Subsequent experiments as to the physiological effects of chloral hydrate induced Dr. Hall to make a trial of this agent in cholera, and his practice has been followed by others with satisfactory results, so far as the reports at present extend.—*Lancet*, May 2, 1874.

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*Solubility of Croton-chloral.*—Dr. Y. C. Wallick states (*Lancet*, April 18, 1874) that while croton-chloral is dissolved with difficulty in water, he finds that it is greedily taken up by ordinary proof-spirit, five or even ten grains being readily soluble in as little as half a drachm of the spirit, to which any quantity of water may subsequently be added.

—

*New Method of administering Iodine.*—P. Collis reports (*L'Union Pharm.*, 1874, April) that Prof. Boldeau has obtained very satisfactory results by using, in the hospital of Beaujon, an iodated albumen, prepared as follows: A solution of albumen is continually agitated with iodine in very fine powder, or dissolved in a suitable vehicle; the liquid assumes at first a deep brownish-black colour, which disappears after several hours, and starch is then not coloured blue by it. The solution is now evaporated to dryness, at a low temperature, and made into pills, each containing five milligrammes ($\frac{1}{13}$ grain) of iodine, of which five or six may be taken in 24 hours.—*Am. Journ. of Pharm.*, June, 1874.

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*Table-fork swallowed by a Crazy Man; five or six years afterwards the Patient committed Suicide, when the Fork was found in his Stomach.*—A case of this had been communicated to the *Union Médicale*, April 9, 1874, by Dr. Baillarger.

A second case, communicated by M. Lascols, is published in the same Journal for 11th April. The subject of it was a married woman who in a fit of anger left her husband to go to her mother. When alone in her chamber she secretly swallowed a table-fork, a servant was charged with having stolen it, and the lady, though requesting that the servant should not be accused of the theft, did not reveal what she had done, and she lived as usual, not suffering much pain. After some months, however, the fork caused her pain and produced an enlargement of her stomach. A consultation of physicians was held, and M. Quairoche made an incision into the stomach and withdrew the fork, which had become perfectly black. The patient recovered and subsequently had children. Several similar cases are referred to in the *Gaz. Hebdom.*, for April 10, 1874, p. 228–9—one recorded as early as the year 1716.

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*The Sarcotome.*—Dr. Hollis, of St. Bartholomew's Hospital, on the 8th inst., exhibited at the Clinical Society an ingenious little instrument, to which he has given the above name, and which appears worthy of special attention. It is constructed with the view of cutting through the soft tissues of the body painlessly, and consists essentially in substituting, as a cutting apparatus, a waxed thread tightened by a spiral steel spring for the caoutchouc tubing which has hitherto acted as the elastic ligature. The spring is confined in a small metal tube closed at one end, and wormed as a screw at the other, in order to receive externally a ring. A short cylinder sliding over the metal tube is fixed to one end of the spring by means of a screw passing through longitudinal slits in the sides of the tube. Lastly, a metal cap fits on the closed extremity of the tube, and the free end of the cap is formed into a ring of metal, so arranged that one opening is terminal and the other lateral. When arranged for use, the free extremity of the spring

is forced against the closed end of the tube by means of the sliding cylinder. A waxed thread or other ligature is placed round the parts to be severed; the surgeon then passes the ends of the ligature through the terminal opening of the cap and out at the lateral one, and fastens the ends by a screw-nut fixed on the outside of the cylinder. The spring is next released by removing the ring, and its whole pressure is then exerted upon the ligature. The instrument exhibited at the Society weighed less than 1½ oz., was about 3 in. in length, and capable of exerting a pressure of 11 lb. The inventor claims for the sarcotome many advantages over the elastic ligature, inasmuch as the instrument can be used with any form of ligature, thus diminishing the risk of breakage. A constant known pressure may be kept up for any length of time by occasionally readjusting the ligature, and in the few cases in which it has been used by Mr. Callender the operations were absolutely painless. The weight of pressure is indicated by a graduated scale on the inner cylinder.—*Lancet*, May 23, 1874.

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*Removal of Both Ovaries.*—Mr. C. G. Wheelhouse, Surgeon to the General Infirmary at Leeds, reports (*Brit. Med. Journ.*, March 21, 1874) it has once fallen to his lot, on removing an ovary in the case of a young lady aged 19, to find that the other one was also in a state of incipient disease. This he removed at the same time, and thus perfectly unsexed his patient.

"It is three years ago this month since the operation was performed, and I have watched the case ever since with the greatest anxiety. There has never been any attempt at menstruation, nor has any vicarious discharge ever taken the place of the natural one; but, beyond this, I see no change of any kind. The general health is now as perfect as it ever was, and, so far from any uncomfortable symptoms of masculinity having occurred, the voice remains as soft, the bust as full, and the whole aspect and demeanor are as perfectly feminine as in any other young lady of my acquaintance."

*Deaths from Chloroform.*—A death from chloroform occurred on Friday, the 3d inst., at University College Hospital, under the following circumstances: A man, thirty years of age, who is said to have been a heavy drinker, presented himself at the out-patient department with a deep-seated abscess in the submental region, which it was decided to aspirate. On account of the dangerous proximity of the ranine artery, chloroform was administered, in order that perfect stillness might be insured. The patient struggled much during the administration of the anæsthetic, but subsequently became quiet, though not perfectly insensible. The needle of the aspirator was introduced at this stage, but as the operation was likely to be a long one, more chloroform was about to be given, when it was found that the patient had suddenly become very pale, and that the pulse had stopped. Notwithstanding all the means adopted to save the patient, he did not rally. Altogether not more than three drachms of chloroform were given, and none was administered for at least two minutes before the threatening symptoms were observed. At the autopsy the heart was found healthy, the left cavities were empty, but the right contained a considerable quantity of dark brownish-red fluid blood mixed with fine granular clot. The lungs were emphysematous, but otherwise sound.—*Lancet*, April 11, 1874.

Another case occurred on the 13th of April, at St. Mark's Hospital, London.

A. R. P., aged 48, a seaman, was admitted into the hospital on April 9th, with a fistula *in ano*. He had been for three months an in-patient at the Seaman's Hospital at Greenwich; and he said that he there had been operated upon for the fistula several times, and had taken chloroform *twice*. He was a tall, well made man, not fat, and not emaciated. His countenance was rather worn. An examination of his lungs and heart detected no disease. On Monday, April 13th, he came into the operating theatre, to be operated upon by Mr. Allingham. Chloroform was administered by Mr. Baly, the resident surgeon; it was given on a small square of lint, the chloroform being drop-

ped on it out of a drop-bottle; altogether not more than *one drachm* was used. The man appeared to bear the anæsthetic very well. There was a little struggling, but not much, with no marked lividity of countenance; and in about the usual time he became insensible to pain. There was no stertorous breathing. Mr. Allingham had laid open one sinus, when the resident surgeon exclaimed that the patient's pulse had stopped. Instantly the tongue was drawn out of the mouth, and artificial respiration commenced. The chest over the region of the heart was slapped with a wet towel, and ammonia was applied to the nostrils. The breathing feebly continued for a few seconds, and two distinct gasps were made, after which the man was dead. The pulse could not be felt, nor the heart heard to beat, after the moment that Mr. Baly said the pulse had failed.—*Brit. Med. Journ.*, April 18, 1874.

Mr. KEENE reported to the Medical Society of London (*Lancet*, May 16, 1874) another death occurring in a woman, aged 50, admitted into the Central London Ophthalmic Hospital, for double glaucoma, and the anæsthetic was administered to produce anæsthesia during an operation for iridectomy.

*The Carlisle Patriot* for May 8th (*Lancet*, May 16, 1874) contains the particulars of another case. The wife of a physician while lying upon a sofa inhaled chloroform from a handkerchief for the relief of facial neuralgia, and death ensued.

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*The Preservation of Food.*—At the meeting of the Academy of Medicine in Paris on March 31, M. POGGIALE read a report which had been made to the Sanitary Council of the Department of the Seine, on a process for preserving meat proposed by M. Tellier, a civil engineer. The process consists in keeping the chamber or vessel containing the meat at a temperature of about 30 or 32 deg. Fahr. M. Tellier objects to ice, as it gives off moisture, and does not lower the temperature sufficiently or uniformly; he prefers dry air, or rather fluid currents at a temperature of 14 to 17.5 deg. Fahr. In his establishment at Auteuil, the cold is produced by the evaporation and condensation of methylic ether. The apparatus consists of a *frigorifère* in which the ether is evaporated, a condenser kept cool by a stream of water, and a force-pump. The ether-vapour, escaping from the *frigorifère* at a tension of about one and a half atmospheres and a temperature of —5.8 deg. Fahr., is subjected in the condenser to a pressure of six, seven, or eight atmospheres. The vapour is thus liquefied, and the fluid returns into the *frigorifère* without any sensible loss. This alternation of gaseous and fluid states is constantly maintained, and produces cold. M. Poggiale had seen at Auteuil mutton, hare, partridge, pheasants, etc., in a perfect state of preservation, though they had been kept for weeks and even months. Some of the meat and game was roasted and eaten, and was found to be excellent. These observations were confirmed by MM. Bouley and Péligot. M. Poggiale exhibited some specimens to the Academy, all of which were in good condition; and, in reply to a question from M. Blot, he said that they would remain good for three or four days, like ordinary meat. The game, however, was stated by M. Poggiale and M. Bouley to lose its flavour to a considerable extent. Ordinary butcher's meat is less affected in this way. It is said that M. Tellier proposes to form a vast establishment for the preservation of food in South America.—*Brit. Med. Journ.*, April 11, 1874.

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*Cinchona cultivation in the Northwestern Provinces and Punjab.*—It is stated (*Indian Med. Gaz.*, April, 1874) that the attempts to cultivate cinchona in the northwestern provinces and Punjab have failed, the plants being killed by the frost. The enterprise has consequently failed.

—

OBITUARY RECORD.—On the 6th of May, at Cheswick, of acute bronchitis, accompanied by cardiac deficiency, RICHARD WILLIAM TAMPLIN, F.R.C.S., in the sixty-first year of his age.

Mr. Tamplin was well known to the profession by his lectures on *Deformities* published in 1846, and by other contributions to orthopædic surgery.

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The work has long enjoyed the confidence of the medical and scientific world, both in this country and abroad, and the exhaustive revision which it has undergone at the hands of its distinguished compiler's son, will enable it to sustain its well-earned reputation of being the best medical dictionary extant.—*Missouri Clinical Record*, June 1, 1874.

In the new edition this valuable work has been brought fully up to the requirements of the profession of the present day. We consider it, and commend it to our readers as, by far the best work of the kind in our language.—*The Peninsular Journal of Medicine*, Detroit, Apr. 1874.

Such comprehensiveness as has been attained in the successive enlargements made, while going through several editions, makes this work one of great value. It contains much instruction which could not be obtained by most practitioners in any other way; and, indeed, is invaluable to all as a work of reference. It should be looked upon as an essential part of a physician's library. We are glad to see that particular attention has been paid to the accentuation of terms.—*Boston Med. and Surg. Journal*, May 28, 1874.

This is a new edition of the most popular medical lexicon in the English language, enlarged and revised by the son of the lamented author, Dr. Richard J. Dunglison. The reputation which the dictionary has enjoyed for forty years, at home and abroad, will be fully sustained and even enhanced by the present edition of the work. It is fortunate for the medical profession of our country that the son has inherited the qualities of mind which fitted the father in so eminent a degree for the work of a lexicographer. The fate of Dunglison's Dictionary is secure. In the hands of the son it will be kept up to the full measure of excellence which has left it for nearly half a century almost without a rival. It is safe to say that it will be found on the table of every American physician.—*Am. Practitioner*, June, 1874

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**HENRY C. LEA—Philadelphia.**

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Clinical Lecture on a Case of Abscess of the Tibia.* By WILLIAM S. SAVORY, F.R.S., Surgeon to St. Bartholomew's Hospital, London.

Let us consider for a few minutes the case of abscess in the tibia, which is still in Abernethy ward. Ever since Brodie first called attention to this disease—now more than forty years ago—it has always been of striking interest, inasmuch as surgery, by a very simple operation comparatively free from risk, can not only afford sudden and complete relief from excruciating pain, but can avert the gravest evils—the loss of limb or life. In the diagnosis too, although a high degree of probability may usually be reached, yet an amount of uncertainty must always remain, sufficient to cause the steps of the operation itself to be watched with the keenest anxiety; and the surgeon can hardly know a moment of greater pleasure than when he sees pus ooze up through his incision in the bone: it is doubly welcome, for it is at once evidence of a correct diagnosis and the guarantee of a successful operation.

T. L——, twenty-one years old, very much under the usual size and still bearing the marks of old rickets, was admitted into the hospital on the 17th December, 1873, with the following history: That four years ago he had first noticed swell-

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ing of the leg. The swelling was accompanied with much pain, especially at night. For some time after it was first noticed it increased very gradually in size. It then became stationary. The pain had subsided after the first onset of the disease, and had even been for a long time absent, or only occurred at occasional intervals. During the few months previous to admission it had again become more frequent, and for about a month had been at times unbearable. On being closely questioned, he remembered, having been struck on the leg with a cricket-ball seven years ago, but there was no history of injury of more recent date.

On admission, there was a smooth, hard swelling of the left tibia about the junction of the upper and middle third. The limb at this point measured about an inch more than its fellow at the same level. The swelling rose gradually from the normal surface of the bone, and sank as gradually below into it again; it was tender, especially about its summit, and the skin covering it was mottled with a bright pink colour, was partially adherent to the periosteum, and somewhat puffy. He complained of excessive aching pain in the bone—pain which was seldom absent, but which was peculiarly severe at night. Iodide of potassium in three-grain doses was ordered, and the case was carefully watched. During the first few days he obtained very little sleep, only dozing for a few hours after morphia or opium. The morning temperature was little above the normal, the evening temperature from 100° to 101°. Leeches were applied, and the quantity of morphia increased, but with only slight temporary relief.

As the pain continued, and the loss of sleep began to tell upon his general health, I determined to cut down upon the bone, and if necessary to trephine it. Many of you were present at the operation on the 28th of January, when I made a longitudinal incision over the summit of the swelling, through the skin and thickened periosteum, and then with a small saw made a similar incision through the wall of the bone itself. You saw how suddenly pus welled up through the wound, and that then a small trephine was applied and a portion of bone removed. An abscess cavity, perfectly circumscribed, was thus opened, containing about six or eight drachms of laudable pus, lined, as one could feel with the finger, by a smooth velvety surface, and measuring some three inches in length. The pus was evacuated, and a small strip of oiled lint was inserted into the wound. During the first day or two after the operation the patient complained of pain almost as severe as before; but the pain gradually passed off after the removal of the dressings and the application of a poultice. From that time his course has been uninterruptedly good; his temperature has been normal; his appetite has improved; he has slept well. The discharge is gradually diminishing, and the wound is slowly closing.

Such an abscess as this is the result of chronic inflammation of the bone, generally attacking the cancellous tissue. A circumscribed abscess in formed, usually of small size, close to one of the articular ends of the bone. This specimen[1] exhibits well the characters of such a cavity. You see its interior is lined with a thick "pyogenic" membrane, now partially detached. The wall of the bone is not materially increased in size, but the articular end is enlarged, and the periosteum is thickened. The tibia is far more often affected than any other bone, but the ribs, sternum, clavicle, humerus, and femur may also be the seat of abscess. It is not every chronic inflammation, however, which leads to the formation of a circumscribed abscess. If you look at the specimens in the museum you will find comparatively few such abscesses, whilst the shelves are richly furnished with other results of slow inflammation. These specimens[2] are admirable examples of such changes. In the former the cortical portion of the shaft of the tibia is not only considerably thickened, but it is indurated by interstitial formation of new bone. The periosteum is thickened and new bone is produced between it and the shaft of the bone it covers. In the second specimen there is not only induration of the cortex, but the change

[1] Series i., 82. [2] Series i., 53 and 131.

has affected the medulla also, so that at certain points no medullary cavity remains. Between these points there is diffuse suppuration in the interior of the bone, whilst here and there are small openings which communicate with the surface. I need scarcely mention caries and necrosis as the results of chronic inflammation, for scarcely a day passes but those who are in the surgical wards or operating theatre have the opportunity of observing such cases. Occasionally, however, it happens that abscess is combined with one or other of these conditions, of which you cannot have a better example than this,[1] where in an abscess cavity in the upper end of the tibia, precisely similar in all respects to other abscess cavities in bone, lies a small sequestrum about the size of a nut, and perfectly loose. Contrast for a moment the effects of chronic with those produced by acute inflammation. Look at the diffuse suppuration of the medulla after an amputation through the bone, rapidly affecting the whole of the interior of the shaft; or at the inflammation of the surface, leading quickly to the formation of pus between the bone and periosteum, and later to necrosis of the whole or a portion of the shaft. Occasionally there is great difficulty in diagnosing between the effects of chronic inflammation and necrosis. In a previous paper[2] I pointed out this difficulty, and also how it may be avoided—how in chronic ulceration and induration of bone small flakes of necrosed bone often lie at the bottom of the fistulous canals, leading down to its surface, and how, by keeping in the line of such tracks, these small flakes are detected and removed, and the disease is thus relieved. There is still one cause of abscess in bone which I have not mentioned—tubercle. You know how this often occurs in or near the articular ends of bones, how it occasionally breaks down and forms a puriform fluid which may be contained in an irregular cavity in the bone, or how it sometimes, as in this specimen,[3] ulcerates into a neighbouring joint. But the abscess thus formed is much more insidious than the simple abscess we are discussing; it seldom gives rise to redness of the skin, or to abiding and severe pain.

In our diagnosis of the disease we are guided by the following points, and you will see how the case before us bears them out. The affection almost always occurs in young subjects, either in children or in young adults. The age of the oldest patient mentioned by Brodie was thirty-four years; but, whilst his age was exceptionable, he serves well to illustrate the second point in connection with the disease. Its duration is said to have been no less than eighteen years, and although this is perhaps the longest case on record, still we find that these cases are generally to be measured by years. Pain is a constant symptom, generally of a dull aching or throbbing character, and especially severe at night. Strangely enough, sometimes apparently as the result of treatment, but often spontaneously, the pain diminishes, or may even cease entirely. But, unless the disease be relieved, it will surely return, and is then generally more severe than before. Exercise or pressure upon the part causes increase of the pain, and is particularly likely to produce its renewal after long remission. The bone at the seat of disease is often considerably enlarged, and its enlargement is due to more than one cause. The collection of pus in the interior produces an actual stretching of the bony wall in spite of its hardness—a fact sufficient at once to account for the force with which the pus wells up after incision has been made, and for the character and intensity of the pain. At the same time there occurs a new formation of bone beneath the periosteum. In some cases this is more marked, in others it is scarcely noticeable, but it is seldom, perhaps never, entirely absent. Tenderness is often a prominent symptom—general tenderness over the whole area of the diseased part—and, in addition to this, more acute and abiding tenderness at some one spot, so that when the finger is applied firmly over this the patient flinches or cries out. The swelling of the part is still further increased by the tumefaction which the soft parts undergo, and by the well-marked thickening of the peri-

[1] Series i., 305.
[2] The Lancet, vol. i. 1864, p. 433.
[3] Series i., 70.

osteum. The integuments are puffy as well as swollen, often pitting slightly on pressure, whilst the skin is often covered, as in this case, by a faint pink blush or mottling, although occasionally it is even paler than normal.

Supposing such a case be not relieved, what should we expect to be the consequence? Why, after many months or even years of suffering, during which the neighbouring joint is not uncommonly the seat of occasional attacks of inflammation, subsiding under rest, but recurring after exercise, and causing continual anxiety for their ultimate result, the matter at length may make its way to the surface, as in an ordinary abscess. Fistulous passages form through the bone and the soft parts, and the pus is discharged; or, far worse, the pus makes its way into the neighbouring joint, and as a consequence, there ensues complete and rapid destruction of it. This specimen[1] is an example of such a catastrophe. The upper end of the bone is hollowed out and worm eaten. The articular cartilages are almost absent. A large opening into the joint exists between them. Unless relieved by amputation, or even after operation, the patient may perish, exhausted by the protracted struggle.

The obvious treatment of abscess of the bone is, of course, to let the matter out. The operation always practised is to cut down upon the bone, turn back the periosteum, and with a small trephine to remove a circle of bone, and thus give exit to the pus. Even supposing that the diagnosis be at fault, that there be no circumscribed abscess, yet the operation is likely to prove beneficial. The disease most liable to be mistaken for abscess is chronic inflammation; and for this condition, when obstinate, as for abscess, the best treatment is to incise the bone. Here, as in similar disease of soft parts, such an incision relieves tension, draws blood from the part, and acts as a drain for the removal of other fluids. By these means pain is relieved more certainly than by any other.

I have chosen this case as a striking illustration of the disease. Its long duration, the age of the patient, the continuous pain increased at night, the appearance of the part, all combine to make it a typical example. Yet there are certain points in which it differs from such cases generally, and not the least important of these is the position of the abscess. This lay, as you noticed, not close to the articular extremity of the bone, but about the junction of the upper and middle third. Again, too, the size of the abscess was much greater than is usually found. It appeared to be about three inches long, and contained from six to eight drachms of pus.

I employed a mode of operating somewhat different from that commonly practised. Instead of trephining immediately, I made a longitudinal incision in the bone with a small saw, and it was not until pus oozed up through the wound that I used the trephine. This appeared to me a simpler operation than trephining; it was likely to give great relief in case there should be only chronic inflammation; and it gave a much wider range, and consequently an increased probability of finding pus if any were present. For you know it has happened that a small abscess has just been missed by the trephine, a mistake discovered only after the amputation of a limb, which might have been saved by so simple an operation.—*Lancet*, June 6th, 1874.

[1] Series I., 163.

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*Fetid Bronchitis.*—Prof. Sée, in some clinical remarks at the Charité Hospital, called attention to a woman suffering from phthisis, in whom the expectoration was extremely fetid. M. Sée, after expatiating upon the supposed origin of fetid expectoration, stated that it is to be met with in the following conditions: Gangrene of the lungs, general or partial; Bronchial dilatation (bronchiectesis); Pulmonary phthisis; and lastly, Fetid bronchitis, or, as it is sometimes termed, Fetid bronchial catarrh. He then went through the differential diagnosis between the affection in question and those just named. In the case of the patient under notice, the supposition of pulmonary gangrane is out of the question, as no cavity could be detected either by auscultation

or percussion. On auscultation, large movable râles (*râles mobiles*), can be heard all over the lungs on both sides, and in front; at the back, a slight diminution of sonority is noticed equally on both sides; moreover, the left side presents a certain degree of dulness, and râles of a fixed character are heard in the supra-spinal regions. These physical signs would indicate the presence of cavities in a rudimentary state (*cavernules*). The idea of bronchial dilatation cannot be entertained, as no "souffle" can be heard either to the right or to the left. M. Sée believed the patient was affected with fetid bronchitis, complicated with tuberculosis, as about a year ago she had an attack of hæmoptysis, which would favour the idea of tuberculosis, although not absolutely so, as pulmonary hemorrhage may likewise take place in fetid bronchitis. The general state of the patient, the emaciation, the fever, with other signs in the summit of the left lung, would certainly point to tuberculosis.

*Spinal Paralysis in Children.*—As an example of this affection, Prof. Sée presented a young girl, about 8 years old, who was an out-patient, at the Charité Hospital, Paris, and took occasion to make a few cursory remarks *apropos* of the case. He stated that, in general, the malady announces itself by the following symptoms: agitation, convulsions, the patient becoming insensible, and fever, with or without vomiting, though in the cases previously met with by M. Sée, he had not noticed any fever. In the present case, however, the malady was ushered in by fever. The next point to be noticed in this affection is the state of partial paralysis; only *one* limb is affected, and this may be the left or the right; although some authors have observed the hemiplegic form (leg and arm); also paralysis of the two inferior members, without cerebral disorder. A third point to be considered is the loss of electro-muscular excitability. This is in relation with the number of fibres affected; all the fibres are not necessarily implicated; in this case, the prognosis is favourable, and the return, more or less complete, of this property may be hoped for. Fourthly, sensibility is not in the least affected. Fifthly, the bladder and rectum are always intact. Lastly, infantile paralysis constantly results in atrophy, and which extends to the skin, to the adipose layer, and not only to the muscles, but to all the parts of the limbs, to the tissues, and even to the bones. The development of the osseous system is backward; the diameter or the circumference of the diseased bone, and its length, are much less than that of the healthy bone. All these were well characterized in the patient that elicited these observations. About three years ago, a slight amelioration was noticed in the child; the limb appeared to assume a certain degree of development. The word "atrophy," according to Prof. Sée, is not quite correct as applied to these cases; it is better, he adds, to substitute "defect of atrophy." In this child all confusion of diagnosis is impossible, particularly with paraplegia; or with cerebral affection; or with myelitis, properly so called; or paralysis, dependent on nervous convulsions. From the shortening of the limb, it might have been confounded with coxalgia; in the present case, the shortening of the limb is due to an arrest of development; as for the pain experienced, this is extremely rare in essential paralysis of childhood. With regard to treatment, M. Sée has not seen any great advantage derived from drugs; diet and regimen may be of some service, but speaking generally, he considers the disease as beyond the reach of art. Electricity, it is stated, has effected some cures, but these, to say the least, are problematical.—*Irish Hospital Gaz.*, July 1, 1874.

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*White Piles.*—Prof. Richet delivered, at the Hôtel-Dieu, a very interesting lecture on what he termed "white piles" (*hæmorrhoïdes blanches*), which he uses in contradistinction to bleeding piles, as in the former, instead of a discharge of blood, this is transformed into a sero-mucous fluid, secreted by the diseased parts. After describing the morbid anatomy of external piles, the worthy Professor stated, that white piles are merely ordinary piles in a more advanced stage, and consisted principally

of hypertrophy of the papillary bodies of the mucous membrane. Some medical men, he said, looked upon this condition of piles as less dangerous, or less pernicious to health. But this was a mistake, as the incessant discharge, which at times is so great as to flow down the patient's legs, must in the end act like long continued bleeding; for after all, mucus, like the other secretions of the body, whether normal or abnormal, is nothing more nor less than blood transformed. M. Richet selected this subject for his morning's clinque, *apropos* of a patient in his ward, who has been suffering from piles for the last thirty years. In this case bleeding has for some time given place to a sero-mucous discharge which has so drained the patient, and he is, moreover, so uncomfortable with the constant dripping, that he has asked to be relieved at any price. Excision, continued M. Richet, is the proper remedy for external piles; but, as this operation is attended with great danger, owing to the excessive hemorrhage that sometimes follows, he prefers removing them with hot irons, raised to a white heat. He does not approve of the galvano-caustic, as, while it has the advantage of rapidity of action, it has the great drawback attributed to cutting instruments, that of not preventing hemorrhage, as does Chassaignac's écraseur; or Maisonneuve's wire "constricteur." These latter, however, have the inconvenience of producing permanent constriction of the anus.—*Irish Hospital Gaz.*, July 1, 1874.

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### HOSPITAL NOTES AND GLEANINGS.

*Emphysema occurring during Labour in a Case of Contracted "Flat" Pelvis.*—The following case (*Lancet*, May 2, 1874) is worthy of record from the comparative rarity of the accident, and also as showing the mechanism of labour in the "flat" pelvis.

Ellen C——, single, aged twenty-three, a primipara, was admitted into Queen Charlotte's Lying-in Hospital on the evening of the 10th of December last, in labour. The "waters" had broken some time previously, and the patient had had a severe shivering attack about the same time. Was delivered, at 10.20 P. M., on the 11th, of a female child weighing 9¾ lb. The first stage lasted forty hours, the second six hours. During the latter stage the pains were very strong, and the expulsive efforts extremely violent. The head, which was the presenting part, did not advance until the patient was placed on her hands and knees, after which the labour made rapid progress, and she was delivered in that position. The placenta came away in twenty minutes. Two hours afterwards there was flooding, which was with difficulty arrested. She experinced no difficulty in breathing, nor was she conscious that anything had happened to her chest during the labour. She stated that she had always had most excellent health, and, with the exception of smallpox, had had no illness of any kind; no cough; family healthy; parents living. Had fretted much whilst "carrying" the child, and during the last two months had vomited much.

Next day she complained of sore-throat, and on examination of the cervical region emphysematous crackling was discovered extending over the face and the front of the neck, but more on the right side. The face was puffed. No cough. Chest sounds normal.

On the 13th the emphysema had extended over the front of the chest, still keeping more to the right side. From the course and direction of the air, it appeared probable that the rupture of the air-cells had taken place in the right lung near its root; thence the air had escaped into the middle mediastinum, and ascended alongside of the trachea and the large vessels into the cellular tissue beneath the skin of the face, neck, and chest.

The sore-throat of which the patient complained was evidently dependent on the air diffused into the cellular tissue of the neighbourhood of the pharynx. The emphysematous crackling entirely disappeared in seven days. There was a considerable rise in temperature and in the frequency of the pulse during that period.

The child's head was remarkably flattened, and looked as if it had been com-

pressed between two boards, the fore and back part of the head were so equally projecting; very slight caput succedaneum; the plane of the sagittal suture was nearly horizontal; on either side of the head, reaching behind the ears, were raised red marks, similar to the impressions made by the blades of the forceps —in fact, they might have been easily mistaken for such. Over the occipital protuberance was a swollen red patch, which afterwards sloughed. No force was used to the head during its passage through the pelvis or outlet. The two former marks were evidently made by the head pressing against the sacral promontory and the symphysis pubis, the latter against the arch of the pubes. The pelvis was examined carefully later on, when there was found considerable flattening of sacral promontory and the body of the pubes, with shortening of the conjugate diameter of the inlet. The course and direction of the marks on the side of the head exactly corresponded with the description given by Spiegelberg in his paper on the "Mechanism of Labour in the Common Forms of Contracted Pelvis." The head enters the inlet in the transverse diameter, and the sagittal suture runs in a transvese direction and very near to the posterior wall. The head makes two rotations, one on the occipito-frontal axis, and the other upon its transverse axis. In order to facilitate this action, the force (when the head has been partially moulded) should be downwards and backwards. If the woman is placed on her hands and knees, the uterus falls forwards and the axis of the body of the child would form an angle, looking anteriorly with the axis of the head in the brim: consequently the head would rotate on its occipito-frontal axis, the sagittal suture coming forwards.

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*Varicocele treated by the Elastic Ligature.*—J. L., aged 22, was admitted into the Queen's Hospital, Birmingham, under the care of Mr. West, on May 3d, he having a varicocele of some weeks' duration. On the 9th the vein was ligatured with an elastic ligature by Mr. West. On the 14th the ligature had cut its way nearly out, and was then removed. The patient was discharged well on May 27th, the vein being obliterated by a firm clot, but no suppuration taking place during the progress of the case.

The elastic ligature has also been used in two cases of nævus by Mr. West and Mr. Wilders. In both cases the ligature came away on the fifth day, leaving a healthy granulating sore, and the children have been completely cured of the deformity caused by the nævi.—*Lancet*, July 4, 1874.

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*Stricture of Rectum; Colotomy.*—Mr. Jordan, at the end of April, at the Queen's Hospital, Birmingham, performed Amussat's operation in a case of obstruction of the rectum from cicatrization following extensive ulceration. The patient has made a most complete recovery. In a case of epithelioma of the anus and rectum, in which both ischio-rectal fossæ were filled with large indurated masses, the same gentleman removed about two inches of the lower end of the gut by means of two semilunar incisions commencing at the posterior wall of the vagina, passing close to the tubera ischii of either side, and meeting posteriorly behind the coccyx. The whole of the indurated mass was in that way removed. The extensive wound thus produced was much diminished by approximating its sides anteriorly and posteriorly by means of sutures. The gut was drawn down and loosely stitched to the margins of the opening. The patient is doing well.—*Lancet*, July 4, 1874.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Rötheln, or German Measles.*—Dr. J. Lewis Smith reports (*Sanitarian*, July, 1874) that this rare disease is now prevailing in the city of New York. He has statistics of the disease as it appeared in twenty-one families, examining and treating the cases in eighteen of them. In the remaining three families the symptoms and histories were so fully and clearly described to him that he has not hesitated to accept the cases as genuine.

In the twenty-one families there were forty-eight cases.

Premonitory symptoms were absent or mild. In a considerable number of the cases it was not known that the patients were sick until the rash was observed covering the surface. Sometimes children preparing to go to school were observed to have the rash, although they had eaten their meals regularly, and complained of no ailment. In one or two instances they were sent from school because the teachers observed the rash, although they felt well enough to continue their lessons. Others were a little dull, or complained of nausea or slight headache from one to three days previously to the occurrence of the eruption. In one case only were there grave premonitory or initial symptoms, namely, in a boy of eight years, who had clonic convulsions.

The rash appeared first either along the back or chest, or upon the face or neck, and, as in measles, it extended downward, not appearing upon the legs till after some hours or on the following day. Its colour was most pronounced on the first day, after which it gradually faded, and by the close of the third day disappeared. The hue, especially after the first day, was usually a dusky red. The rash resembled more that of measles than of any other eruptive fever. In one case, a boy of three and a half years, it presented over the trunk very much the scarlatinous appearance. It commonly produced itching; disappeared on pressure, caused a little roughness, as ascertained by carrying the fingers over the surface, and faded without desquamation.

Occurring simultaneously with the dermatitis, there was a mild inflammation of the mucous membrane, covering the buccal, pharyngeal, and nasal surfaces, and of the reflection of this membrane over the eyes and eyelids, namely, the conjunctiva. This gave rise to sore throat, sneezing, sometimes a slight defluxion from the nostrils, suffused, watery, or reddish eyes, and, in certain cases, a puriform secretion collecting at the angles of the eyelids, and more or less usually slight œdema of the lids. In one case, an infant of 23 months, there was so much œdema coming on the second day that it was impossible to examine the eyes. This swelling declined in three or four days.

The febrile movement was ordinarily mild, the pulse in ten uncomplicated cases ranging from 80 to 100, and the temperature from 98½° to 100°. The appetite was impaired, but not lost; little or no thirst; little or no cough; bowels regular. A common symptom was nausea, and several of the patients vomited. The urine examined in two cases was found normal. The duration of the disease was only three or four days.

The incubative period did not seem to be uniform. In some instances it appeared to be from seven to ten days, and in others from eighteen to twenty-two days, varying, therefore, as in scarlet fever.

Dr. Smith concludes, from his observations, that this disease is a contagious exanthematous fever, allied to measles and scarlet fever, but totally distinct from either. It must be placed in the same category with them. Most cases more closely resemble measles than any other disease, but that there is a specific difference is evident from the fact that those who have had measles are as liable to this malady as those who have not had it. Nineteen at least of the forty-eight cases observed by Dr. Smith had had measles, and some of them only a few months previously. In the Catholic Foundling Asylum, in 68th Street, with which Dr. Smith is connected, measles prevailed as an extensive epidemic in February and March, and this was followed by an epidemic of the new disease, which commenced March 25th, and by the first of May had affected about thirty of the children and three nurses. Of these cases a large proportion had had measles.

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*The Pathology of Insanity.*—Dr. John P. Gray, Superintendent of the New York State Lunatic Asylum, has for several years past been engaged in pathological investigations, and more recently in

special microscopic work, and in the *American Journal of Insanity* for January last gives a brief summary of some points of interest.

He states that, although the cases thus far examined may be regarded as insufficient to establish general conclusions, they go to strengthen the conviction sustained by the laws of general pathology, that insanity is a physical disease of the brain, and that the mental phenomena are symptoms; further, that the microscope, with patient and close investigation, will continue to disclose structural changes in the cerebral tissue, as marked as those heretofore unsuspected, when examinations were limited to the scalpel and naked eye; and in these investigations, when the entire range of the disease, in every stage of its progress, shall have been brought under the microscope, we may be able to solve the problem of the morbid processes denominated insanity.

Another conclusion to which these investigations would naturally lead, is, that the variety and changes in the predominant symptoms of insanity may acknowledge their cause, not so much in the variety of lesions as in the special parts of the cerebral centres which are morbidly involved in each case; or, to bring the idea within narrower limits, that emotional, ideational, and motor disturbances, have their foundation in the extent and degree to which the nerve-elements that minister to the execution of intellectual and motor acts are involved in the lesion. When the disease reaches its ultimate stage, all distinctions cease, dementia being the same closing stage of every so-called form of insanity.

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*Exstrophy of the Bladder.*—In the report of operations performed at the Massachusetts General Hospital published in the *Boston Med. and Surg. Journ.* (June 25, 1874) are given the notes of a case of exstrophy of the bladder occurring in a boy nine years old. Immediately above the penis was a rounded, vascular swelling, covered with mucous membrane, and consisting of the protruded, posterior wall of the bladder; its protrusion varied with the amount of pressure from behind and with the respiratory movements. It was extremely sensitive, and constantly irritated by the contact of clothing. On one side, the testicle had descended, on the other it had not. On the former was a reducible, oblique, inguinal hernia. The open mouths of the ureters could be seen at the lower part of the swelling, and urine constantly dropped from them on the parts beneath. The umbilicus was wanting. An oblong square skin flap, two and one-half inches wide by three and one-half inches long, was dissected from the groin, scrotum, and lower part of the abdomen, leaving a broad pedicle bordering on the mucous surface described; the integumental surface of this flap was laid upon the mucous surface of the bladder, forming an anterior wall. To protect this raw surface, and provide for the lateral wall of the other side, a second skin flap was taken from the same region of the opposite side and laid upon it. The free borders of the flaps were stitched together by silver wire sutures. The raw surfaces left, from which the flaps were taken, were covered, as far as possible, by the adjoining integument, and the remainder left to granulate. Other steps to complete the result were contemplated when cicatrization had taken place.

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*Medical Graduates in* 1874—*continued from page* 107.—

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*Practice of Medicine in Missouri.*—At the last session of the General Assembly of the State of Missouri, a law was passed which makes it unlawful for any person to practise or attempt to practise medicine or surgery in this State without first receiving a diploma from some duly established college or university, and filing a copy of the same with the clerk of the county in which the practitioner resides.

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*Kansas Medical Society.*—At the annual meeting of the Kansas Medical Society, held at Lawrence, May 20 and 21, the following officers were elected for the ensuing year:—

President, Dr. J. S. Redfield, of Fort Scott. Vice Presidents, Drs. T. Sinks, of Leavenworth, and R. Morris, of Lawrence. Secretary, Dr. D. W. Stormont, of Topeka.

The next meeting will be held at Topeka, on the third Wednesday in May, 1875.

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*Kentucky State Medical Society.*—The officers elected for the year 1875 are as follows:—

*President*—Dr. J. Baker, of Shelbyville; *First Vice-president*—Dr. George Beeler, of Clinton; *Second Vice-president*—Dr. J. Y. Newkirk, of Bedford; *Recording Secretary*—Dr. J. A. Larrabee, of Louisville; *Corresponding Secretary*—Dr. B. F. Logan, of Shelbyville; *Librarian*—Dr. J. J. Speed, of Louisville; *Treasurer*—Dr. L. B. Todd, of Lexington; *Publishing Committee*—Drs. W. F. Owen, W. H. Galt, and R. H. Gale, of Louisville.

The next meeting of the society will be held April, 1875, at Henderson, Ky.

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Obituary Record.—Died, in Boston, on the 20th of June, aged 55, George Derby, M.D., Secretary of the State Board of Health of Massachusetts, and Professor of Hygiene in Harvard University.

Dr. Derby graduated in medicine at Harvard in 1843, and served with distinction as surgeon in the army during the late war. On the establishment of the Massachusets State Board of Health in 1869, he was appointed its Secretary, and how faithfully he discharged the laborious duties of his office our readers well know.

—— In Philadelphia, on the 2d of July, Gouverneur Emerson, M.D., aged 79 years.

Dr. Emerson is, perhaps, best known to the profession through his valuable statistics of mortality in Philadelphia, which appeared in the earlier volumes of the *American Journal of the Medical Sciences.* For a number of years he had retired from the practice of his profession, though always maintaining an interest in it, and devoted his time more particularly to scientific and practical agriculture. He was a man of general culture, and a valuable contributor to the literature of farming. Characterized by remarkable placidity, amiability, and unswerving integrity, with good natural abilities well cultivated, and liberal tastes, he was warmly esteemed by many appreciative friends, most of whom he survived.

## FOREIGN INTELLIGENCE.

*Warts upon the Margin of the Lid.*—Although warts upon the margin of the lid may, in most cases, exist for years without giving any annoyance, yet two cases have lately occurred within a short period in Prof. v. Arlt's private practice, in which a wart that had rapidly grown upon the free margin of the lid, gave rise to an acute catarrh of the conjunctiva, without any direct mechanical irritation of the membrane. Prof. v. Arlt smiled at the suggestion of the patient, that the wart might be the cause of the conjunctivitis. Only after a lengthened treatment with various applications had proved fruitless, did he determine to snip off the wart, when, to his astonishment, he saw the conjunctivitis disappear in a few days. In the second case, which had been under treatment elsewhere for conjunctival catarrh without benefit, he proceeded at once to remove the wart, and obtained a rapid cure of the inflammation. To Arlt this experience was new, and it may be that the observation will be of use to other practitioners.—*Irish Hosp. Gaz.*, July 1, 1874.

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*Amussat's Plan for the Ablation of Tumours by Means of the Thermic Galvano-Caustic Process.*—Since 1852, M. Amussat has employed several plans for the ablation of tumours by means of the thermic galvano-cautery. He first pedicellated them with steel grooves, also intended to direct the course of the platinum wire; at a later stage he removed them with the galvanic *sécateur;* then with the platinum bistoury. Ablation with the *sécateur* is one of the most simple plans of operation, and the one to which M. Amussat generally has recourse. But when the tumours do not pedicellate well, the thread slips, and the section is not satisfactorily performed. To obviate this

inconvenience, M. Amussat places one or more ivory stems in the plane of the section, below which he makes the end of the thread pass before introducing them into the *sécateur*, and thus makes certain of the regularity of its action. In the case of a lady who had an ulcerated tumour in the internal portion of the mammary gland, one ivory stem was enough to guide the thread, and allow a very clean section of the tumour, without the least flow of blood. This very simple plan is applicable to tumours of all kinds which do not pedicellate sufficiently. — *London Med. Rec.*, July 1, 1874.

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*Surgical Anæsthesia.* — M. Fornes, a French naval surgeon, urges the advantage of putting a patient asleep by administering chloral hydrate previously to his inhaling chloroform for the purpose of anæsthesia. — *Le Mouvement Médical*, June 27, 1874.

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*Foreign Body in the Male Urethra; Ingenious Extraction.*—In the tenth number of the *Bulletin de Thérapeutique* (1873), Messrs. Andant and Lonstalot mention the case of a gentleman suffering from stricture, who was in the habit of passing an elastic catheter for himself. One day, through absence of mind or some other cause, he passed the instrument (No. 7) commencing by the end to which the bone ring is attached instead of the proper end supplied with the eye. After reaching the perineal region, he attempted to withdraw the catheter, but the latter returned without the ring, which had become detached and remained in the urethra. Dr. Andant was sent for and requested by the patient to push the ring into the bladder, as pain and a wish to pass water had supervened. At a consultation with Dr. Lonstalot it was resolved to use the following contrivance: A No. 7 catheter was obtained at a chemist's, and the bone ring being taken to a smith, an iron rod of the same diameter as No. 7 was chosen, one end of which was turned so as to act as a screw, fitting the grooves of the bone ring. The instrument was put into the hands of the patient, because, by long practice, he had learned the peculiarities of his urethra. Dr. Andant had, however, previously introduced a silver catheter with great caution, and ascertained the presence of the bone ring in the urethra. The patient was directed, when reaching the ring, to roll the free end of the rod in his fingers, so as to introduce the male screw into the ring. This was very cautiously and cleverly done, and when it was supposed that the rod was sufficiently fixed, it was slowly withdrawn, and the ring was brought to light, to the great satisfaction of both the patient and the surgeons.— *Lancet*, May 23, 1874.

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*Hæmorrhoids.*—Dr. William Colles, of Steevens's Hospital, Dublin, has lately suggested treating hæmorrhoids by injecting the tincture of the perchloride of iron. He had some time since a case of internal hæmorrhoids under his care, and used this method, twenty minims being injected into each hæmorrhoidal tumour; and on the rectum being explored by a speculum some weeks afterwards, no traces of the piles could be discovered except a few nodules of cuticle, each of the size of a shrivelled currant. The case had been previously treated without avail by the application of fuming nitric acid, a remedy first suggested by the late Dr. Houston of Dublin.—*Brit. Med. Journ.*, June 27, 1874.

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*Treatment of Varcies by the Local Employment of Perchloride of Iron.*—Dr. Linon, of Verviers, has used perchloride of iron locally with great success during the last three years in the treatment of varices. The strength of the solution is about two and a half drachms to eight ounces of water. Compresses of flannel are steeped in the water, then wrung out, and applied by means of a flannel bandage, which is only to be moderately tightened. This application is to be kept on twenty-four hours, and on removing it the surgeon is much surprised to find that the venous dilatations have almost entirely disappeared. The applications are to be renewed as above during seven or eight days successively, after which time the bandage is to be kept on, with-

out any further wetting, till it gets loose. It is then to be wetted again with the solution, and applied, until the varices have disappeared, which generally takes place after eight days or a fortnight, according to the size of the swelling. These simple means have removed in a few days enormous varices, accompanied by violent pain, with black spots on the surface, and have restored to the patients the use of their limbs. By the unsuccessful application of dry bandages only, Dr. Linon has been able to show that it is not compression, but really the local action of the iron which is efficacious. The local action of the thermal waters containing magnesia on the skin is similar to that of the perchloride. Thus at Luxeuil patients affected with varices derive great benefit from the Benedictine pond. — *Lancet*, June 6, 1874.

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*Camphor in Erysipelas.*—M. Revillout states (*Gaz. des Hôpitaux*, June 20) that he has several times had occasion to employ with good result in erysipelas an application used by M. Delpech at the Necker. It consists in painting the affected surface with a solution of camphor in ether (equal weights); and when this is employed in erysipelas of the face, and the affection has not yet reached the hairy scalp, its progress is usually arrested. It is also very useful in erythema caused by local irritation.—*Med. Times and Gaz.*, June 27, 1874.

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*Prurigo and Ulcerations in Variola.*—Dr. Guéneau de Mussy recommends (*Ann. de Dermat.*, 1874, No. 3) the following pomade when the itching in variola is excessive: Cerate thirty grammes, bromide of potassium three grammes, and camphor three decigrammes. When the pustules are followed by ulcerations, he prescribes the following pomade: Cerate thirty grammes, tannin, oxide of zinc, of each two grammes, calomel two decigrammes, and watery extract of opium one decigramme.—*Med. Times and Gaz.*, May 9, 1874.

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*Chloral in Trismus and Tetanus of Newborn Children.*—D. A. von Huttenbrenner (*Jahrb. d. Kinderheilk.*, H. 1, 1873) has made a trial of chloral hydrate in the above cases, and, on the strength of his own experience, added to that of Steiner, Auchenthaler, Monti, etc., thinks he is justified in arriving at the following conclusions: 1. Tetanus is a disease which is not necessarily fatal. 2. The cause of the disease is febrile or not; in the former case it is but a partial manifestation of general poisoning of the blood; in the latter it consists of reflex spasms excited by peripheric irritation. 3. Prognosis is more favourable in cases unattended by fever, though it is not necessarily unfavourable in cases accompanied by fever. 4. Chloral hydrate is far from being a specific for tetanus, but its employment must be recommended because it is a pure hypnotic, which does not determine congestion of the brain as morphia does, is easily administered to children, and finally has been undoubtedly successful in a great many cases.—*Lancet*, May 30, 1874.

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*Lemon-juice in Diphtheria.*—M. Revillout recommends (*Gaz. des Hôpitaux*, June 20) in the strongest terms the employment of large quantities of pure lemon-juice as a gargle. He says that he and his father have used it during eighteen years, and always with success, it being the most certain application yet known.—*Med. Times and Gaz.*, June 27, 1874.

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*Nature of Fluid Discharged in Coryza.*—At a recent meeting of the Société de Biologie, M. Ranvier stated that on examining with the microscope the fluid discharged from the nose at the commencement of coryza, he found that it contained a large quantity of cellular elements, some of cylindro-conical form with a flat surface crowned with cilia, others strongly granular and turgid, in which the flattened surface and cilia had disappeared. Rindfleisch was of opinion that these cells were white corpuscles covered with cilia. It was of great importance to determine if these were really leucocytes, or only deformed epithelial elements. On warming them, some of the cilia could be seen

to recommence their movements, but no amœboid motions were observed. They are, therefore, not white corpuscles of the blood. M. Ranvier has been still more satisfied of this, after examining them in iodized serum. The use of the amniotic liquid of the sheep, highly iodized, enabled him to recognize the fact, in conformity with the statements of M. Bernard, that the white corpuscles of the blood, or the lymph corpuscles, contained considerable quantities of glycogen. In fact, when leucocytes are immersed in iodized serum, they may be seen to acquire a characteristic violet-brown colour. But the cells with vibratile cilia met with in the mucus of coryza, though assuming, indeed, a yellowish tint under the influence of iodized serum, do not give the peculiar reaction of glycogen. It would hence appear to be clearly made out that these are not young elements proceeding from the blood, but that they are the epithelial cells of the mucus.—*Lancet*, June 20, 1874.

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*On the Curability of True Croup without Emetics.*—Dr. Klemm narrates (*Jahrbuch für Kinderheilkunde*, vol. vi.) a case of croup which was treated by packing in the cold wet sheet. The packing was repeated every three or four hours for the first day or two. The child recovered. Three other cases, similarly treated with the same result, are alluded to. Klemm deems the sweating which accompanies the packing to be not less beneficial than the abstraction of heat. It is important that the treatment should be begun early in the disease, before the false membrane has been abundantly formed.—*London Med. Record*, June 24, 1874.

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*On Polypiform Vegetation of the Trachea after Tracheotomy.*—Dr. Peter called the attention of the Société Médicale des Hôpitaux, on December 26, 1873 (*L' Union Médicale*), to the details of a case in which tracheotomy had been successfully performed on a child aged three, attacked by croup. The canula could not be removed for three months, as each attempt to do so produced an access of suffocation. Finally it was removed; but it was observed that in any rapid effort, or in attacks of anger or alarm, suffocative dyspnœa was brought on. Finally, in such an attack, the child died suddenly. There was found at the inferior angle of the tracheal cicatrix a polypiform vegetation, incapable itself of giving rise to suffocation and death, but capable of exciting fatal spasm. M. Bergeron related a similar case; and in the course of the discussion which followed many remarkable cases were mentioned, indicating that small growths, at a distance from the vocal cords, are capable of exciting distressing and even fatal accesses of laryngeal spasm; and that sessile granulations at the seat of a tracheal wound require careful attention before the canula is withdrawn after tracheotomy.—*London Med. Record*, Feb. 25, 1874.

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*Chloral in the Treatment of Spasmodic Asthma.*—Dr. C. Theodore Williams (*Brit. Med. Journ.*, June 13, 1874) speaks highly of the use of chloral in asthma.

In slight cases, he says, it should be administered in doses of twenty to thirty grains once or twice in the night. In severe cases, fifteen or twenty grains should be given every three or four hours until sleep is induced. In by far the majority of instances of neurotic asthma, this treatment has succeeded in allaying the spasms, and in diminishing, or even abolishing, the attacks.

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*Double Aneurism of the Thoracic Aorta.*—Dr. Theodore Williams exhibited to the Pathological Society of London, May 19, a specimen of double aneurism of the thoracic aorta. The disease was in the descending aorta. The first aneurism was ruptured, and had caused death. The sixth and seventh ribs were eroded. The second projected into the right pleural cavity, and was also eroding. The heart was large, the left ventricle greatly hypertrophied, and the valves diseased. The aorta was much diseased. The upper sac opened into the vessel two inches below the left subclavian by a buttonhole aperture; the lower two inches further down by a hole as large as a florin; and the two sacs further com-

municated with each other. The patient, a commercial traveller of thirty-seven, had suffered for years with symptoms of dilatation of the aorta and cardiac enlargement, and at last a pulsating tumour appeared at the left side of the spine, which threatened to burst. Death, however, suddenly took place from internal hemorrhage, with epistaxis. Only three similar cases had been recorded in the *Transactions*.—*Med. Times and Gaz.* June 27, 1874.

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*Enemata of Bromide of Potassium in Obstinate Vomiting.*—Dr. GIRABETTI has obtained the very best results from the administration of enemata of bromide of potassium, in doses of from one-half to two drachms, in cases of obstinate vomiting attending the pregnant state. The same drug, also administered in enemata, has been very successful in the hands of Dr. Laborde, of Paris, in obstinate vomiting, connected with disease of the stomach, liver, and intestines.—*Lancet*, May 30, 1874.

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*On Morbilli Bullosi sive Pemphigoidei.*—Dr. STEINER narrates (*Jahrbuch für Kinderheilkunde*, vol. vii.) four cases of measles, attended with an eruption of bullæ. The patients were sisters; and the cases are the only instances of the kind which Steiner has observed out of 6000 of measles. The bullæ appeared on the face, scalp, back, chest, hands, feet, mucous membrane of the mouth, nose, and vulva. The blebs appeared one day after, two days after, at the same time as, and half a day before, the eruption of measles. The bullæ came out in crops, and continued to appear after the measles had ceased. One child, a baby of ten months, died in consequence of pneumonia.—*London Med. Record*, June 24, 1874.

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*On Pregnancy with Persistent Hymen.*—M. DUFOUR (*Archives de Tocologie*, June, 1874) was consulted by a lady for some abdominal enlargement. On feeling the tumour, the movements of a child were apparent. On proceeding to make a vaginal examination, his finger was prevented from entering the passage by a complete circular band, which ocular demonstration proved to be the hymen. In leucorrhœa the parts sometimes become much relaxed, and rendered thereby very dilatable, so that under certain circumstances the act of coitus may by completed without any rupture of the hymen. In this case the patient said that she had never suffered from the "whites," and this was substantiated by the condition found.—*London Med. Record*, June 17, 1874.

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*On Closure of the Uterus by Sutures after Cæsarean Section.*—A paper on this subject by Dr. VEIT, of Bonn, was read before the Berlin Obstetrical Society on Oct. 28, 1873. He disapproves of Martin's method of stitching the uterus to the abdominal walls, as tending to produce laceration of both wounds. He considers it most desirable that the uterine wound should be closed. Not only may Lister's catgut sutures be left with impunity in the peritoneal cavity, but also, the knot becoming undone, the stitch falls into the cavity of the uterus to be afterwards discharged with the secretions. Under these circumstances, Dr. Veit describes two cases in which he operated. In the first, he closed the incision in the uterus by means of eight catgut sutures, and the abdominal wound with ten silk ones. The patient recovered without a single bad symptom. In the second instance, seven deep and two superficial catgut sutures were used, the abdominal incision being closed with the material. After many relapses the case ultimately did very well. Dr. Martin related, at the same meeting, the case of a patient convalescing most favourably, in which he had used Veit's plan.—*London Med. Record*, June 17, 1874.

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*Oatmeal as Infant's Food.*—In a communication to the Société Médicale des Hôpitaux, MM. DUJARDIN-BEAUMETZ and HARDY make known the results of the employment of oatmeal on the alimentation and hygiene of infants. According to them, oatmeal is the aliment which by reason of its plastic and respiratory elements makes the nearest approach to

human milk. It also is one of those which contains most iron and salts, and especially the phosphate of lime so necessary for infants. It also has the property of preventing and arresting the diarrhœas which are so frequent and so dangerous at this age. According to the trials made by M. Marie, infants from four to eleven months of age fed exclusively upon Scotch oatmeal and cow's milk thrive very nearly as well as do children of the same age suckled by a good nurse. —*Gazette Méd.*, April 4, *Med. Times and Gaz.*, April 18, 1874.

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*Detection of Alcohol in Organic Fluids.* —It is generally difficult to detect alcohol in organic fluids on account of the small quantity of liquid usually available, and the absence of a special reactive. M. Berthelot has discovered a very valuable reaction. When placed in presence of water, cold or tepid, benzoic chloride ($C_{14}H_5ClO_2$) decomposes very slowly. But if alcohol is added, benzoic ether is immediately formed, and precipitates into the chloride in excess. The presence of the ether becomes manifest when a few drops of the liquid are treated with a solution of caustic potash; the chloride alone is dissolved, and the ether remains untouched. This reaction is very marked with a liquid containing 1 per cent. of alcohol, and permits the chemist to dispense with distillation.—*Lancet*, June 20, 1874, from *Tribune Médicale.*

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*Motor and Sensory Nerves.*—In 1863 M. Vulpian contended that the filaments of the sensory and motor nerves perform the same function, and that their physiological properties were not radically different. He based this opinion upon the following experiment. The hypoglossus (motor) and the lingual (sensory) having been cut, the central end of the lingual was connected by a suture with peripheral end of the hypoglossus. Three months after this M. Vulpian laid bare the central segment of the lingual, separated it from the brain by section, and irritated the stump of the lingual prolonged by the hypoglossus. The operator provoked distinct movements in the corresponding half of the tongue, and then concluded that a sensory nerve can act as a motor nerve under certain circumstances. But M. Vulpian has lately given up this view, and freely confesses his error. He ascertained that one of the branches of the chorda tympani which arises from the facial (which is a motor nerve) accompanies the lingual during its distribution to the tongue. Hence it cannot be maintained that the movements excited in the first experiment were entirely dependent on the action of the hypoglossus. By further trials M. Vulpian found that the chorda tympani is solely concerned in the movements obtained after the connection artificially brought about between the lingual and hypoglossus.—*Lancet*, April 18, 1874.

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*Death from Chloroform.* — Mr. J. T. Clover reports (*Brit. Med. Journ.*, June 20, 1874) a case of death from chloroform occurring in a patient of Mr. John Marshall to whom the anæsthetic was given prior to the removal of some adenoid growths from the posterior nares.

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*British Medical Association.*—The forty-second annual meeting of the British Medical Association will be held at Norwich, on August 11, 12, 13, and 14, under the Presidency of Edward Copeman, M.D., Senior Physician to the Norfolk and Norwich Hospital. The address in Medicine will be delivered by Dr. Russell Reynolds, that in Surgery, by William Cadge, Esq., and in Obstetrics, by Dr. Matthews Duncan.

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*International Medical Congress.*—This body will meet at Brussels from September 19 to September 26, 1875, and a committee has been organized to make the necessary preparations. It consists of M. Vleminckx, President of the Academy of Medicine, and the three Vice-Presidents, MM. Deroubaix, Bellefroid, and Crocq, together with M. Warlomont, who acts as secretary.

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*University of Vienna.*—It is announced that Prof. Rokitansky is about to retire from the chair of Pathology in this University. Prof. Von Recklinghausen, of Strasburgh has been invited to become his successor.

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Clinical Lecture on Sciatica and its Treatment.* By FRANCIS E. ANSTIE, M D., Physician to Westminster Hospital, etc.

GENTLEMEN: There is a man now in Burdett ward who is the subject of simple sciatica, and whose case affords me the opportunity of making some practical remarks on that disease and on its treatment. I am glad to be able to do this, not only because the complaint is very painful and troublesome, and may give you a great deal of anxiety when you have to deal with it in practice, but also because the statements respecting it which you will meet with in many books are erroneous and confusing. Before I say anything about sciatica in general, I will briefly relate the symptoms and course of our patient's illness.

[After relating the details of this case Dr. A. gave the following reviews of the current doctrines as to its pathology:] There are very few diseases which are more frequently misrepresented in treatises on medicine.

The principal source of error regarding the nature of sciatica is to be found in the inveterate tendency, especially among English physicians, to explain every disease by the light of a humoral pathology. No doubt the mania for "blood-poisons," "vitiated secretions," and the like, is only one degree more foolish than was the exclusive solidism which has reigned in other

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periods; but the former has proved itself especially injurious to the progress of rational nervous pathology and therapeutics. The universal hypothesis of depraved blood and secretions has had to be so violently strained to meet the case of nervous diseases, that it has done more than common mischief to the scientific intelligence of those who have forced it to this use.

The most popular theory in this country concerning sciatica refers the origin of that disease to the gouty diathesis. If you look into the medical text-books, you will find that the majority of them take it for granted that this connection is at least very common; and from my own experience in consultation with other medical men, I know that this idea is very generally diffused. Indeed, practical evidence of the fact is abundantly furnished by the prescriptions for sciatic patients which are continually met with. In these it is quite the rule for colchicum to figure as a leading remedy, and for the remainder of the treatment to consist of the prolonged administration of alkalies, varied at times by the use of iodide of potassium. Now, the question whether this kind of treatment is appropriate or not is very important; for if the medicine does not cure it is likely to do a good deal of harm. Colchicum, especially when administered for any length of time, is a very depressing remedy; and the prolonged use of alkalies is scarcely less so. And, in fact, I have practically found that a large number of patients have suffered seriously in general health from this plan of treatment, without getting any relief from their sciatica. When I began practice I was as strongly impressed with the gouty theory of sciatica as any one; but the results of treatment directed in that sense were so discouraging that it became necessary for me to reconsider the whole subject. More careful investigation of the personal and family history of patients suffering from sciatica, speedily convinced me that the gouty theory was at any rate only applicable on a very limited scale. From a very large number of records of cases of sciatica collected by me in hospital and private practice during the last sixteen years, I find that not more than one-fourth admitted even of a suspicion as to gouty origin; I mean, that not more than one-fourth of the patients had any knowledge of gouty symptoms, either in themselves or in any blood-relation. And even among those who had some personal or family history of gout, there were not a few as to whom it was difficult or impossible to suppose that the gout had any essential connection with the neuralgia. When any one asks you to accept a general statement that a particular local disease is usually or frequently dependent upon a particular diathesis of the body, I recommend you, before acquiescing in such a statement, to picture to your minds, as clearly as possible, the characteristics by which the diathesis can be identified. Now, it is tolerably easy to form such a picture of the gouty diathesis, or at any rate to fix on a certain minimum of evidence, without which we have no reasonable grounds for supposing that an individual possesses the gouty constitution. If a patient has, himself, repeatedly or even once, had a genuine attack of gout, one must admit the probability that he is of the gouty diathesis; but we ought to inquire very strictly as to the character of the attack. No one ought to be said to have had gout, unless he is known to have suffered, once or more, from hot and painful swelling of one or more of the smaller joints (far the most commonly the metatarso-phalangeal joint of the great toe), which attacked him suddenly *in the night*, and lasted from two to seven days; or unless, indeed, we can find the visible evidence of past gouty action in the presence of chalk-stones (lithate of soda) in his joints or in the cartilages of his ears. Where it is not alleged that the patient himself has had an attack of regular gout, but that he has shown the symptoms of latent gout, we must be very careful how we accept such a statement. The symptoms which may lead to a suspicion of latent gout are chiefly as follows: The patient is liable to dyspepsia, with acid regurgitations; he not unfrequently gets slight attacks of giddiness without obvious cause; and, above all, his urine varies between light colour, with low

specific gravity, and occasional discharge of large quantities of lithates and more or less uric acid in the form of crystalline sand. Such a group of symptoms may, no doubt, give *primâ facie* grounds for suspicion of the gouty diathesis, but they really amount to very little, unless there is another item of evidence—viz., a history of gout in other members of the family. Gout is so exceedingly hereditary that we can usually find evidence of this kind; and there is reason for very great doubt as to the gouty character of symptoms like those which have just been described, when we are able to explore the history of one or two generations and yet do not find any record of the developed disease. Supposing, however, that we do get a history of what was called gout in other members of the patient's family, it is still our duty to inquire very carefully into the circumstances, for we are continually told by unprofessional people that "so-and-so had gout," when in fact he had rheumatism, or even some form of joint affection altogether independent of constitutional disease.

By employing this strict manner of investigation, we reduce to a very humble level the pretensions of gout to be ranked as a cause of sciatica. Nevertheless, there is a grain of truth in the notion. The classes of society in which we find families that have hereditary gout are also those among whom nervous diseases are most frequently propagated from one generation to another; and thus it happens that a neurotic and a gouty race are not very unfrequently blended by marriage. A certain proportion of the descendants from such a marriage will possess a strong union of these constitutional peculiarities; and it is not to be for a moment denied that the gouty element does in such cases aggravate the tendency to nervous mischief, and especially to neuralgia. In such persons the things that bring on gout are apt to provoke neuralgia much more surely than they would in another kind of constitution. This is especially true of indiscretions in diet, and particularly of the use of beer or port wine. You will bear this fact in mind, then, although you will avoid the common error of looking at all cases of sciatica with a foregone prepossession to the gouty theory of their causation.

The question whether sciatica is related, and if so in what degree, to the rheumatic diathesis next presents itself for our consideration. It opens a very difficult inquiry; but the results we may obtain from that inquiry are exceedingly important in a practical point of view, since they must exercise a great influence on our plans of treatment.

In considering whether rheumatism has any better title than gout to be considered the cause, or a frequent cause, of sciatica, it is first necessary that we should have some clear ideas as to what we mean by "rheumatism."

By most Continental writers, especially by the Germans, anything in the shape of pain which is immediately provoked by *cold* is called rheumatism; and in this sense it is undoubtedly true that a large number of cases of sciatica are rheumatic in origin. In this country the word rheumatism is not usually employed in so lax a fashion, although there has no doubt been much vagueness and a great want of agreement as to any precise definition. For my own part, I hope that future changes may be in the direction of making the separation between rheumatism and various chronic painful affections—especially neuralgia—more distinct; for it is plain to me, from my own experience, that the opposite course leads to endless confusion. I shall, therefore, try to get you to realize, as distinctly as possible, what are the maladies to which alone we ought to apply the name of rheumatism. 1. I need not tell you, in the first place, that there is a febrile affection, with acute inflammation of the joints, commonly called "rheumatic fever," and which is characteristic and unmistakable; 2. There is a chronic form of the same malady, frequently but not always occurring as a sequel to repeated acute attacks, and usually affecting only a limited number of joints. Accompanying both these forms of disease, but especially the former, there is a well-known tendency to inflammatory affections of internal organs, but especially of the pericardium and the

endocardium. But, besides this, there is a characteristic hue of the skin, a peculiar pallor conjoined with a distinctly yellow tinge on the palmar surfaces of the fingers and various other places, and in acute or subacute attacks a tendency to viscid perspiration, which gives the skin an oily look, and causes it to exhale a sour smell. High acidity of the urine is another well-known characteristic. In the above described affections we recognize a well-marked type of disease which must continue to receive the distinctive name of rheumatism; but the moment we pass outside this line we find ourselves involved in confusion when we apply the term more widely. It is, for instance, a gross abuse of language to apply the term rheumatism to the terrible "arthritis deformans"—that malady which, without any febrile commencement, attacks a vast number of joints, and, partly by changes of the cartilages and ligaments, partly by the deposit of large quantities of bony matter around the joints, gives rise to the most painful and crippling deformities. Every circumstance of the pathology and etiology of this disease distinguishes it utterly from the true rheumatism. It is not less inexpedient, in my opinion, to apply the term "muscular rheumatism" to those painful affections of the muscles to which Dr. Inman very properly gave the distinctive name of myalgia; for these affections (under the form of lumbago, pleurodynia, etc.) quite as commonly attack persons who are free from, as those who are subject to, the tendency to rheumatism in joints. But the confusion becomes worse confounded if we allow ourselves to speak of neuralgia, in its ordinary forms, as a local evidence of the rheumatic diathesis; for in a very large majority of the cases of neuralgia we find not the smallest evidence that the patients have any recognizable features of the rheumatic diathesis. A few cases of really rheumatic neuralgia do undoubtedly exist, and I wish to give you clear ideas of the nature of this affection, which, however, is so rare that you may possibly never meet with it in the whole course of your practice. It occasionally happens—and perhaps more frequently in sciatica than in neuralgia of any other nerve—that the origin of the mischief has really consisted in rheumatic inflammation of the sheath of the nerve. It may convince you, however, that this kind of sciatica must be comparatively very rare, if I tell you that in the course of sixteen years' hospital and private practice, in which I have seen over ninety cases of sciatica, not more than four presented the truly rheumatic character. These all occurred in persons who had shown other evidences of genuine rheumatism; in all of them there was a palpable thickening of the nerve-trunk or of one of the principal branches. The first case of the sort that I saw was one in which the peroneal nerve was so remarkably enlarged, in a thin patient, that my attention was necessarily drawn to it. That this was the original seat of the mischief seemed evident from the fact that the pain was limited to the sensory branches of the peroneal nerve, the two points of greatest agony being situated at the division into two branches of the musculo-cutaneus (lower third of the leg, outer side), and on the dorsum of the foot, just at the lower border of the annular ligament; and that if one pressed a finger on the swollen nerve, a dart of acute pain immediately shot into the situations just named. Such cases might, perhaps, be confounded with examples of those secondary changes which I have often described to you as occurring, in old cases of neuralgia, in the tissues around the distribution of the painful nerves; but the latter conditions are not attended with definite enlargement of a considerable nerve-trunk, and, above all, they develop but slowly, whereas rheumatic sciatica occurs as rapidly as does rheumatic inflammation of a joint. You perceive, then, that, except in a very small and well-defined class of cases, there is no pretence for speaking of sciatica as a rheumatic disease.

One constitutional disease, however, not only is capable of producing sciatica, but probably does so with unsuspected frequency—viz., constitutional syphilis. It had always puzzled me to read of the marvellous successes which some observ-

ers had obtained with iodide of potassium in sciatica (seeing that in the ordinary forms of the disease I never found it useful), until I came across cases in my own practice where syphilis was evidently the cause, and in which I obtained immediate success by the use of that drug. I would advise you, in every case of sciatica that does not quickly yield to the kind of treatment which I shall presently recommend, to inquire very closely into the history of the patient as regards the possibility of his having had syphilis; and to show you the necessity of not being too readily diverted from the quest by apparent improbabilities, I may mention that one of the most marked successes I have obtained was in the person of a gentleman whose peculiar position seemed to put syphilis entirely out of the question. Here the primary syphilis dated as many as thirty years back, but a clear history of subsequent, though not severe, constitutional symptoms was obtained, and the treatment by iodide of potassium in large doses at once effected a brilliant success.

In the vast majority of cases of sciatica, however, you will find no trustworthy evidence of any diathetic condition resembling either gout, rheumatism, or syphilis; and you will be driven to the conclusion that the disease is a neuralgia pure and simple. Now let us ask ourselves what are the principles which should govern our prognosis and treatment of neuralgia in general and of sciatica in particular.

In regard to neuralgia in general, we are in the unfortunate position of lacking any positive information as to the precise seat and nature of the pathological change which is at the root of the malady. I say "positive" information, because post-mortem examinations of persons who, at the time of death, were suffering neuralgia, have been so rare that practically, from this side of the matter, we know but little. But we know enough to be quite certain that the apparent site of the pain need not be, and indeed scarcely ever is, the seat of the mischief which causes it. It is demonstrable, from accumulated clinical facts, that pathological causes which irritate the nerve high up in its trunk produce pain at the peripheric distribution; and it is also known that sensations which are excited by irritation of the central origin or nucleus of a sensory nerve, are, by a regular physiological law, referred to the periphery. As regards sciatica, we happen to possess precise knowledge of the immediately *exciting* cause in a considerable number of cases; for there is a rather large number of recorded instances in which irritative pressure of a loaded bowel, a gravid uterus, or a tumour, upon the nerve within the pelvis, has set up pains, distributed in the peripheral manner already described, and disappearing instantaneously on the removal of the cause of irritation to the trunk. But in regard to all neuralgias, a strong argument for the belief that the cause operates centrally rather than peripherally, arises from the fact that the pain simultaneously affects individual twigs of nerve which are widely separated from each other. In a facial tic, *e. g.*, it is not at all uncommon to find that the pain centres in two points—the supra-orbital (above the notch of that name) and the auriculo-temporal (in front of the ear); the former representing the frontal branch of the first or ophthalmic division of the trigeminus, and the latter representing the auriculo-temporal branch of the third division. Now, it might be said that the operation of some peripheral cause, such as cold, had excited pain in both these points of nerve; but clinical experience entirely forbids us to explain the matter thus, because the independent affection of widely separated twigs of the same nerve is quite as frequently observed where it is perfectly obvious that no peripheral irritation has been at work. If, then, the pain in two widely distinct twigs of the same nerve were not caused by irritation acting at the apparent peripheral site of the pain, we may next inquire whether the mischief is in the trunk of the nerve; and in a considerable number of cases of neuralgia we shall find that a portion, at least, of the mischief was caused in this way. Irritative pressure upon the trunk of a nerve has frequently, at any rate, so much share in the produc-

tion of a (peripherally felt) neuralgia, that the latter disappears immediately on its removal; thus a syphilitic periostitis may cause irritative pressure on a nerve within a bony canal, and anti-syphilitic treatment may immediately remove the pain. But we are bound to ask ourselves whether the irritation of the nerve-trunk is the whole matter, and for this reason—that various nerves, and especially the sciatic, from their anatomical position, are extremely frequently pressed upon by viscera, or by tumours of various kinds, and that if this cause were alone sufficient to produce neuralgia, that disease ought to be a hundred times more frequent than it is. It is not enough to prove, as we readily can, that the immediate cause of some cases of sciatica was the pressure of a loaded bowel, for, considering the very great frequency with which people carelessly allow their bowels to remain chronically constipated, sciatica ought to be one of the commonest diseases in existence, if the mere pressure were, in itself, enough to set up the disease. But sciatica is far from being a common malady, and we are therefore compelled to suppose that a predisposition to neuralgia existed in the nerve.

Now, in favour of the idea that some *predisposition* is usually, if not always, present in neuralgic patients, and that peripheral irritation only serves as the final factor which elicits it, there is a very large mass of striking facts. Of these the most important are those of heredity: nothing is more certain than that neuralgic patients nearly always descend from families in whom the disposition to nervous diseases of various kinds is markedly developed. For detailed proof of this I must refer you to my work on "Neuralgia and its Counterfeits" (Macmillan), merely observing that since the publication of that book I have received a very large amount of corroborative evidence of the position now laid down. It has, indeed, been very confidently ascribed by a recent writer,[1] that, whatever may be the case with neuralgia in general, no proof can be made out of the hereditary character of sciatica; to which statement I can only reply that the very considerable number of fully noted cases of sciatica which I have collected from my own observation, entitles me to say that sciatica holds a similar position to that of facial or other neuralgias as regards the question of direct and indirect inheritance. It is an offshoot of that neurotic constitution, the inheritance and the alternate transformations of which, in successive generations and different individuals, is so marked a feature in the history of many families. I do not wish now to occupy your attention too long with theoretical considerations, but in the work to which I have referred you you will find what I venture to believe is very strong evidence in favour of the opinion that the mysterious neurotic inheritance consists of an inherited tendency towards imperfect building of the central nervous system—the last and highest expression of the increasing tendency to differentiation of organs which corresponds with the upward scale of development in the animal series. I believe that sciatica follows the same rule which pertains to other neuralgias, and that underlying the fact of the external provocation which may have immediately induced the attack, there was a predisposition, the origin of which is to be traced to a feeble and mobile constitution of the centres in the cord from which the sciatic nerve takes its rise.

We will assume, then, that sciatica, in nearly if not quite all cases, requires a predisposition of that kind which descends in families that have marked tendencies to nervous disease. What, if any, are the particular circumstances which specially distinguish sciatica as regards the tendency to its immediate provocation, and the circumstances which are likely to make it a transitory or a lingering affection?

In the first place, the sciatic nerve is, beyond all others, obnoxious to the evil influence of muscular movement. Its large size, and its position among the muscles of locomotion, expose it to continual drags and pulls, and if once neuralgic pain has been set up in it the slightest amount of walking is sure to

[1] Dr. H. Lawson.

aggravate it and keep it up. And then, unfortunately, the exposed position of a large part of the nerve, from the sciatic notch downwards, makes the sitting posture equally bad with locomotion. In fact, there is no position except lying prone upon a couch, which does not more or less worry the nerve. It is probably to their less energetic habits of locomotion that women owe their remarkable immunity, as compared with men, from sciatica. The most thoroughly obstinate and intractable case that I have seen in a woman was one in which the patient would not, for a long time after the commencement of her illness, take the physical rest which was imperatively required, but continued to limp about for hours daily. By the time this had been going on for some three months the case was thoroughly hopeless as regarded cure.

No disease is more markedly influenced by age than sciatica. It very seldom occurs before the age of twenty, and the zenith of its frequency is between the ages of forty and fifty. There are, indeed, two quite different types of sciatica, putting aside the gouty, the rheumatic, and the syphilitic varieties (which have no constant relation to age). The sciatica of youth may be a severe complaint, and if injudiciously treated may become intractable and even wholly incurable; but, as a rule, it distinctly tends to spontaneous termination, except in so far as it is kept up by some vicious habit of body or mind. The effect of imprudent efforts to "walk it off" may convert what would have been a very trivial and temporary attack into a very obstinate one. Sexual excesses, especially masturbation, have an unquestionable tendency to provoke and to keep up sciatica in comparatively young persons, and alcoholic intemperance is a possible influence in the same direction. But it is essentially the neuralgias of later life—those which come on from the age of forty to fifty or later—which prove intractable and often incurable. The great rule, which holds true of all neuralgias, that the commencement of the process of bodily decay inaugurates a period in which the cure of these maladies becomes increasingly more difficult, applies in full force to the case of sciatica; and more especially is this effect observed where the degeneration of arteries forms a prominent and early feature in the tissue-degradations of the period of vital decline.—*Med. Times and Gaz.*, May 30, 1874.

(To be concluded.)

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## HOSPITAL NOTES AND GLEANINGS.

*Dislocation of Odontoid Process from Caries; Sudden Death.*—The notes of the following rare and interesting case, treated at St. Thomas's Hospital, London, are given by Mr. Samuel Osborn, Surgical Registrar.

The patient was a hairdresser, aged fifteen. About Christmas time he first noticed a stiffness of his neck, which was apparently relieved by friction with ammonia and oil. One month ago the stiffness returned in his neck, and he again used some liniment. The stiffness never entirely disappeared. It hurt him to throw his head back, and when he turned his head it seemed to shake his limbs, and when wanting to pick up anything he would sit down, instead of stooping in the usual manner. It was noticed that whenever he was not at work he would sit in a corner of the room, supporting his head against a jack-towel suspended from the wall. He never complained of great pain until the last three weeks, and then only when he bent his head forwards; but the pain increased during the last fortnight, so that he applied at the hospital on June 2d, but he was not then admitted, his case not being considered sufficiently urgent. After this he got worse, and complained more, and stated that when he bent his head forwards it caused a severe pain all down his back; he also complained of headache, and fancied his head was swelling. The pain in the neck increased in severity, the stiffness became more decided, and the lymphatic glands became enlarged, so that he applied again to the hospital on June 9th and obtained a letter of admittance. When seen in the out-patient room, numerous glands were found to be enlarged on the left side of his neck, but these were ascribed to pediculi found in his head, and to his being

slightly out of health. He was ordered to have his hair cut short, and to apply a lotion of bichloride of mercury, two grains to the ounce.

The symptoms detailed above referring to the head and neck were elicited from his friends after death. On arriving home he appeared quite cheerful, and ate a good hearty meal. In the afternoon, when the liniment was being rubbed into his neck and his head was bent to the right side, he screamed terribly, and a little later, about three hours after returning from the hospital, he complained of a numbness in his left hand, which he was unable to lift. His friends rubbed his arm with dry mustard, and it appeared to get better. About 8 P. M. his legs became numbed, and the numbness in the arms appeared to get worse; he said it felt like pins and needles. At 10 P. M. he appeared to have a difficulty in breathing, and was obliged to be undressed and carried to bed. At 3 A. M. on the 10th his mother went in to see him, and gave him some cold tea. He then complained of the numbness in his arms and legs, and when, at 6 A. M., she again went in to dress him, he appeared cheerful, and was desirous of getting up; but he appeared to have a difficulty in breathing. She gave him his medicine, and almost immediately afterwards he went into a kind of fit, and became blue about the face and lips. They sent for the nearest surgeon, who ordered his immediate removal to the hospital, directing his friends to take the medicine with him, believing him to have been poisoned. He was removed to the hospital, and on his arrival, at 7.30 A. M., was found to be dead, with his head lying upon his chest.

At the post-mortem examination, on the body being opened, all the internal viscera were found to be quite healthy; and, on opening the skull, the brain was also found perfectly healthy; but, on close inspection of the interior of the skull, the odontoid process of the axis was found filling up the foramen magnum, having ruptured the check and the transverse ligaments, perforating the meninges of the cord, and pressing upon the spinal medulla. The lower part of the medulla oblongata at the seat of pressure was softened and pulpy, and a collection of matter had found its way between the membranes and the cord. The occipito-atloid articulation of the left side was carious and entirely disorganized, and occupied by an abscess cavity, which had probably burst at the point where the odontoid process had perforated the dura mater. The posterior part of the anterior arch of the axis, as well as the anterior edge of the foramen magnum, were also carious.

The above case, which resembles one recorded at p. 160 of Mr. Le Gros Clark's book on Diagnosis of Visceral Lesions, presents many points of interest in the obscurity of the symptoms, in the rarity of the disease, and also in showing the importance of opening the skull in all post-mortems. Although this happened to have been done in this instance, the chance of the cause of death being overlooked was great, for on the head dropping backwards no sign of anything amiss could be detected; it was only on bending the head forwards that the odontoid process came into view, and death must have occurred whilst the head was in this position.—*Lancet*, July 11, 1874.

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*Cases illustrating the Use of the Elastic Ligature.*—The value of the elastic ligature is well illustrated in the subjoined cases treated by Mr. Lawson Tait in the Birmingham Hospital for Women.

In the first case it was specially suitable. It is, indeed, in the instances of vascular growths so situated that cutting operations are inadmissible, that the gradual strangulation chiefly triumphs. The *modus operandi* tends materially to diminish the risk of hemorrhage, while in operations of no great magnitude the danger of the supervention of phlebitis is but small, at least not greater than after the use of the knife, the cautery, injections, or the ordinary ligatures.

M. B., aged twenty-five, admitted December 25, with a large varicocele of left labium, which gave rise to much discomfort from the excoriations and discharge. Its removal had been attempted in another institution, but the hemorrhage had been

so alarming that it was not persisted in. According to her own account, the patient had to be watched night and day by dressers.

*Feb.* 2. Mr. Tait passed a double elastic ligature through the base of the tumour by means of a trocar, and tied it in opposite directions, so that each half of the ligature embraced half of the base of the tumour. A quarter of a grain of morphia was at the same time injected under the skin of the arm.

*4th.* The tumour quite black, and nearly separated.

*7th* The separation is complete, and a healthy granulating surface about three inches in diameter is left, to which red lotion was applied as a dressing.

Very little pain was complained of after the first twenty-four hours, and there was never the least hemorrhage. On the 23d of the month the wound was almost healed.

H. S., aged thirty-three, admitted Jan. 5th with a deep and very sinuous fistula leading from about two inches to the left of the anus through the ischio-rectal fossa to an aperture in the rectum about three inches up. An elastic ligature was passed and tied on the 26th, and it came out on the 30th. Considerable pain was felt for a few hours after its insertion. The track healed perfectly, and the patient was discharged cured. In this case the advantage of the ligature over the knife was that it saved all loss of blood, and, as the patient was very anæmic, that was a point of importance.

M. P., admitted April 27th, suffering from three perineal fistulæ, one opening to the right of the right labium, and the others about an inch and two inches respectively to the right of the anus. The uterus was quite fixed, and the history given indicated the occurrence of a pelvic hæmatocele some months previously, and its subsequent suppuration. These fistulous tracks led up into a cavity behind the uterus, from which a very abundant discharge flowed after its exploration.

*May* 1. Two elastic ligatures were passed, one through the track opening in the labium, and the other through the principal track to the right of the anus into the suppurating cavity, and thence through an opening made into the rectum, and then they were tied through the rectum. They made their way out on May 4th and 5th. A few days later the discharge was coming entirely through the rectum.

*19th.* The discharge has very much diminished in quantity, and the patient is now able to sit comfortably, as she has not done for many months.—*Lancet*, June 27, 1874.

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*The Automatic Man.*—Under this appellation an account is given in the *Gazette Hebdomadaire* of July 17, of a curious case which has come under the observation of Dr. Mesnet, of the St. Antoine Hospital. A young man during the late war had a portion of the left parietal, about eight centimetres in extent, carried away by a ball. Hemiplegia of the right side was the consequence, but this gradually disappeared. For some time past he has been the subject of attacks, lasting from twenty-four to forty-eight hours, attended by very extraordinary phenomena. During these he seems to act exactly like an automaton, walking continuously, incessantly moving his jaw (*machonnant*), knitting his brow, and appearing absolutely insensible to all that surrounds him. Not uttering a word, he walks straight forward, and when he meets with an obstacle, stops short, explores it with his hand, and tries to pass on one side of it. Surrounded by a circle of persons, he stops at each, and endeavours to pass by the intervals formed by their joined hands, then turns back, comes in contact with the next person, and resumes his round. All this time he never manifests the slightest consciousness, just as if he were in a state of somnambulism. He is absolutely insensible to pain, so that pins may be thrust through the cheek or into the fingers, or very powerful electrical shocks may be administered without the slightest sensibility being manifested. What, however, is very remarkable, is that by bringing him in relation with certain objects we are enabled to determine in him the entire series of acts which are correlative with the sensation thus aroused. Thus,

if a pen be placed in his hand, he seeks for ink and paper, and writes a letter in a very good hand, in which he speaks very sensibly about different matters which concern him. If a leaf of cigarette paper is placed in his hand, he feels in his pocket for the tobacco, rolls up the cigarette very adroitly, and, having found his match-box, lights it. If the match be extinguished just as it reaches the cigarette, he finds another, and that several times, until he is allowed to light his cigarette. If at the moment when the match is extinguished, another already lighted is presented to him in its place, it is impossible to induce him to light the cigarette by means of the substituted match. He allows his moustaches to become burned without offering any resistance, but he will not employ the light thus presented to him. If chopped charpie be placed in his pocket instead of his tobacco, he makes the cigarette with this, and lights and smokes it without seeming to pay any attention to what he is smoking.

Among the various experiments devised by Dr. Mesnet, there is one which is particularly curious. The young man is a singer at concerts by profession, and if gloves be placed in his hands he immediately puts them on, and searches for paper. When a roll of this, resembling music in form, is given to him, he places himself in the proper position and begins to sing. It would seem, in fact, that tactile sensation induced in him becomes the point of departure, and as if of escape, of a series of acts correlative to this initial sensation —acts which he accomplishes automatically, without letting them deviate from their habitual and regular succession. Lastly, it is to be noted that, while in this singular condition, the patient steals all that comes within his grasp. If he touches any person, he feels for his watch-pocket, and invariably detaches the watch and puts it in his own pocket, whence it may be immediately removed without his making the slightest opposition. The crisis once over he has no recollection whatever of what he has been doing, and becomes again perfectly reasonable.

The questions that such a case gives rise to for the reflection of the physician and psychologist are striking. How, indeed, is such a fact to be characterized? and what idea is to be formed concerning the modifications of the functions of the nervous system which it exhibits? A no less interest must be felt by the medical legist, for evidently during these crises such an individual must be absolutely irresponsible. But how, under similar circumstances, are the facts to be ascertained? What precedes is a mere sketch of some of the features of this curious case. Dr. Mesnet, armed with all the resources derived from a consummate experience in the study of mental diseases, has had it for some time under investigation, and will immediately publish a memoir upon the subject.—*Med. Times and Gaz.*, July 25, 1874.

## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Ulceration of Vermiform Appendix; Abscess.*—Prof. H. B. Sands exhibited at a recent meeting of the New York Pathological Society (*New York Med. Journ.*, Aug. 1874) four small fecal concretions, which were interesting from the fact that they were discharged from an abscess resulting from peritonitis, consequent on ulceration of the vermiform appendix.

They were from a gentleman aged forty-one years. Having left his residence in the morning of April 23d, in his usual health, in the afternoon he suffered great pain, diffused over the abdomen; nausea and vomiting. He felt cold, but had not a distinct chill. The vomiting and nausea subsided after a few hours, but the pain in the abdomen continued, being most severe in the right iliac region. He was seen with Dr. Ball on the following evening, at which time he presented symptoms of localized peritonitis, also in the right iliac region. No decided change had taken place by April 26th, three days after attack. The abdomen was slightly swollen throughout, but not very tense. The tumour could be felt in the neighbourhood of the cæcum, about as large as the fist, and quite firm to the touch. The question arose as to the true nature of the disease. It might be either—1.

Intussusception; 2. Internal hernia; 3. Impaction of feces; and, 4. Abscess connected with disease or ulceration of the vermiform appendix. To this last diagnosis the surgeons in charge were inclined to hold. From Sunday, April 26th, a record was kept. For about one week after the attack the patient showed signs of peritonitis. The temperature was 101° to 102°, pulse from 90 to 101. Distension of the abdomen became somewhat considerable. It increased up to the fourth day, and then subsided. The bowels were not moved until the sixth day. He then took castor oil and an enema. By this means he obtained two or three copious discharges, causing a feeling of exhaustion, but he soon rallied, and felt very much relieved. On Thursday, a week after the beginning of the attack, there was an amelioration of all the symptoms. The swelling of the abdomen had subsided; no longer any tenderness except over the tumour; pulse normal; temperature 98° and a fraction. The tumour, however, did not disappear; and so long as it remained it was feared that the case would not terminate by resolution. Until the following Monday nothing occurred deserving of mention. On the twelfth day the patient had a moderate chill. The temperature rose to 101°. On the thirteenth, temperature 102°. Coincident with this change in the general symptoms, there was a change in the appearance of the tumour. Previously it was hard, and could not be made to change its shape. Now it became larger and softer, although no fluctuation could be detected. It was a tumour of considerable size. These circumstances determined Dr. Sands to recommend the operation of Dr. Parker. After cutting down through the tissues, an abscess was found. The abdominal walls were very thick, as the man had been in good health; fluctuation was not obtained until after cutting down sufficiently deep. A trocar and canula were then inserted, and about six ounces of fetid pus escaped from the opening. An exploration was then made with the finger. Two of the largest concretions were removed; others escaped subsequently, until the whole number was about eight or nine. The two which first escaped were about the size of a pea. One of them was cut open, but no nuclei were found. The concretion seemed to be fecal, simply—the layers being concentric in their arrangement. The symptoms were immediately removed by the operation—and in due time the patient entirely recovered.

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*Action of Nitrite of Amyl in restoring temporarily a Moribund Patient.*—I. H., aged thirty-two years, labourer, entered the service of Dr. E. G. Janeway at Bellevue Hospital, on May 27, 1874. The history obtained was to the effect that, during the summer of 1872, he first noticed his eyelids to be puffy, and his feet swollen. He continued to work, however, until five months before admission, when increasing debility, complicated with dyspnœa, palpitation, and loss of appetite, developed. When admitted, the patient was anæmic, very pale, and stated that his urine had been suppressed for forty-eight hours. His feet and legs were very œdematous, and the rest of his body to a slighter extent. There was increased area of cardiac dulness, with a double murmur over heart anteriorly and posteriorly, with the qualities of a friction-sound of cardiac rhythm. There were also evidences of slight œdema of the lungs. The catheter removed only a few drops of urine from the bladder. Dry cups were applied over the lungs and kidneys, and half an ounce of infusion of digitalis, with half a drachm of acetate of potassa, given every four hours. The next morning the dyspnœa was improved, and about four ounces of highly-albuminous urine passed. About noon, Dr. Janeway saw the patient for the first time. He was then unconscious. Pupils dilated. No response on touching the conjunctiva. Complete loss of pulse at the wrist, and breathing of a spasmodic character, such as occurs a few minutes before death. Some nitrite of amyl was obtained, and inhalations of five drops, cautiously increased to twenty-five drops, commenced. After the use of twenty drops, the pupils began to contract, and winking resulted from touching the conjunctiva. The pulse

now began to be felt at the wrist. With the use of the last five drops he returned to consciousness, and the pulse at the wrist became full. He was now able to speak, and asked how long he had been faint, and whether or not he would pull through. The inhalations were now suspended, and half an ounce of brandy administered. A man was stationed at the bedside to notify the house-physician of the least approach of dangerous symptoms. In about fifteen minutes another attack occurred, and by the time the physician approached him he was dead.

There can be no doubt that in this case the amyl produced the temporary restoration from all but death, and the subsequent death in so short a time showed the gravity of the case.

The temporary restoration might be at times of great value, and, in a case where the lesions were not serious, might be prolonged into cure and permanent recovery.

Dr. Janeway has not read of any case in which such a near approach of death was warded off, and is of the opinion that, as a rule, it would not be judicious to give such large doses; but, from the fact that a certain amount remained on the towel, it is difficult to say how much in reality the patient inhaled. He does not believe that the nitrite would prove equally serviceable in cerebral hyperæmia producing unconsciousness, the case under observation being one of cerebral anæmia, with failure of the heart's action from pericarditis.

*Autopsy.* Lungs œdematous, with slight hydrothorax. Heart normal in size. Pericardium coated with fibrinous exudation of considerable amount. The sac contained a small quantity of serum. A microscopical examination of the tissue of the heart showed evidences of fatty degeneration in the portions beneath the pericardium. Liver, fatty. Kidneys, of the large, white variety. Evidences of fatty degeneration, with increase of connective tissue. Cortical part of the kidneys anæmic. On one side there was a hydrocele.—*New York Med. Journ.*, July, 1874.

*Estimation of American Medical Publications in England.*—"Whilst it is true that the physicians of the United States have been so largely dependent on English sources for their supplies of medical information, it is now quite apparent that a small but increasing current of medical literature is setting in from the United States to England. Wood's Practice was for a long time much esteemed and largely used as a text-book in England. At the present time Flint's Practice is much read, and as it justly deserves, is considered a marvel of clear and exact statement, of judicious condensation and at the same time fulness of detail. Indeed, I heard one of the most capable men of London assert, that there was hardly a man in England who could write just such a work. Gross's great work on surgery is much consulted, is frequently quoted, and is highly esteemed by the best men. I have had it, also, from one of the most eminent specialists in that department of practice, that Dr. Weir Mitchell's Injuries of Nerves and their Consequences, as well as his other contributions, stand foremost in the literature of these subjects. Hammond on Diseases of the Nervous System is one of the American medical works most largely read and most highly admired. The very accomplished and learned librarian of the Royal College of Surgeons—Mr. Chatto—told me that the American Journal of the Medical Sciences was one of the best journals received at the library from any part of the world. We must observe in these facts hopeful indications for the future of American medical literature."—R. B., in *The Clinic*, Aug. 1, 1874.

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*American Otological Society.*—At the annual meeting of this Society, held at New York July 15, the following officers were elected for the ensuing year: President, D. B. St. John Roosa, M.D.; Vice President, Clarence J. Blake, M.D.; Secretary, J. Orne Green, M.D.

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*New Hampshire Medical Society.*—At the eighty-fourth annual meeting of the New Hampshire Medical Society, held at Concord 9th of June, the following officers

were elected for the ensuing year, President, Nahum Wright, M.D., of Gilmantown; Vice President, S. M. Whipple, M.D., of New London; Secretary, Granville P. Conn, M.D., of Concord.

The semi-annual meeting is to take place in September, at the Isle of Shoals. The next annual meeting will be held at Concord, on the third Tuesday in June, 1875.

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*West Virginia State Medical Society.*—At the annual meeting of this society held at Morgantown, May 27 and 28, the following officers were elected for the ensuing year: President, Dr. M. Campbell, of Parkersburg; Vice-Presidents, Dr. W. H. Sharp, of Volcano, M. F. Hullihen, of Wheeling; Secretary, Dr. Wm. M. Dent, of Newburg.

The society adjourned to meet at Point Pleasant on the first Wednesday in June next.

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*University of the City of New York.*—The following appointments have been made: Wm. A. Hammond, M.D., to fill the Chair of Diseases of the Mind and Nervous System; John T. Darby, M.D., late Professor of Surgery in the University of South Carolina, as "Professor of Surgical Anatomy;" and Montrose A. Pallen, M.D., late Professor of Gynæcology in the College of Physicians and Surgeons, St. Louis, as "Lecturer on the Surgical Diseases of Women."—*Med. Record*, July 15, 1874.

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*Archives of Ophthalmology and Otology.*—This excellent journal has been changed from a semi-annual to a quarterly, and its subscription price reduced to five dollars per year. It is edited by Prof. H. Knapp, M.D., of New York, and Prof. S. Moos, M.D., of Heidelberg, in conjunction with Dr. E. Gruening, of New York, and Dr. C. J. Blake, of Boston. William Wood & Co., New York, are the publishers. The July No., now before us, contains many articles of interest to those devoted to the two specialties named in the title.

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*The Psychological and Medico-Legal Journal.*—This is the title of a monthly review of the diseases of the mind and nervous system and of medical jurisprudence, conducted by Dr. Wm. A. Hammond, assisted by Dr. T. M. B. Cross, and published by T. W. Christern, 77 University Place, New York. It is a continuation of the Journal of Psychological Medicine, edited by Dr. Hammond. We have before us the first two numbers, which are very handsomely gotten up and are filled with interesting matter. We wish it all the success it merits.

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*Archives of Electrology and Neurology.*—This is the title of a new journal, edited by Dr. George M. Beard, which is to be issued semi-annually. The first number, now before us, contains various articles, etc., of special interest to those who devote attention to electro-therapeutics and nervous diseases.

## FOREIGN INTELLIGENCE.

*Acute Rheumatism attended by Cerebral Symptoms without Hyperpyrexia.*—Dr. GREENHOW related to the Clinical Society, of London (*Med. Times and Gaz.*, July 11, 1874), the following particulars of a case of this. A police constable, aged 28, two years ago suffered from an attack of acute rheumatism, during which, according to his own account, his head had been affected, so that he could not remember what had taken place during the time of his illness. Six days before admission, his present attack had commenced with headache, sickness, and pains in the left ankle. When admitted, he presented the ordinary symptoms of rheumatic fever, with a soft friction-sound over the apex of the heart. In the course of a few days, the pains subsided; but there was profuse sweating, and the temperature once reached 103.3° Fahr., the highest temperature recorded throughout the case. On the ninth day after admission (the fifteenth of the disease), the patient became delirious, incoherent, and wandering, with much jactitation of the body, constant choreal movements of the fingers of the left hand, tremor of the right hand, and subsultus. These symptoms continued for five days, and then began to subside;

but, even after the delirium had left him, he remained some days incoherent and childish in manner, and the choreal movements of the left hand continued. These, however, gradually disappeared, and he was discharged convalescent. The treatment consisted mainly in hemlock juice and bromide of potassium. Dr. Greenhow remarked that there was a great resemblance between this case and others which had been brought before the Clinical Society; but at the same time there was a marked absence of the hyperpyrexia which has been supposed by some authorities to give rise to the cerebral symptoms. The case was, therefore, of importance in showing that the hyperpyrexia in cases of this class was not the cause, but the effect of the brain-paralysis; and that it is an effect which is not invariably produced.

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*Oxide of Zinc in Diarrhœa.*—M. Revillout states that in the wards of M. Damaschino oxide of zinc is often prescribed with great success in all the forms of diarrhœa. The usual formula is three grammes and a half of the oxide, and half a gramme of bicarbonate of soda, divided into four portions, to be taken during the day. The soda is added to prevent the production of a soluble salt of zinc with the acids of the stomach. The measure is very efficacious in all forms of diarrhœa, even that met with in phthisis. M. Revillout has also seen many cases in which champagne, administered while effervescing, has proved an excellent remedy in vomiting and the hectic diarrhœa that often accompanies it in debilitated subjects. Young infants, too, suffering from constant vomiting of food, have been enabled to digest raw meat by employing champagne as a drink.—*Med. Times and Gaz*, July 25, 1874.

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*Subcutaneous Division of the Neck of the Femur.*—On Wednesday last, at the Great Northern Hospital, Mr. William Adams performed for the fifth time his operation of subcutaneous division of the neck of the thigh-bone. The patient, a girl, aged 18, began to suffer from disease of the right hip-joint when she was eight years of age; for the last eight years, her thigh had been permanently deformed, flexed, and adducted, so that the knee rested over the centre of the left thigh. She formerly walked with two crutches, but had lately used only one. She had never worn a high-heeled boot of any kind, and the toes of the right foot, when she stood up, were about six inches from the ground. Thus the leg was perfectly useless, and was atrophied. The patient having been placed under chloroform, a sharp-pointed scalpel was inserted from above the trochanter and passed across the front of the neck of the femur. A fine saw was then introduced at the same aperture, and the bone was divided in a little more than four minutes. Richardson's styptic colloid on cotton-wool, carbolic oil dressing, and pads of lint were at once applied. The tendons of the tensor vaginæ femoris, adductor longus, and rectus femoris were then divided subcutaneously, and the whole limb was finally fixed to a long straight outside splint. The limb, which before the operation had been flexed at a right angle to the pelvis, was after the operation placed in a state of complete extension. This was the first case operated upon by Mr. Adams in which the union was not bony, but the movement at the joint was so slight that no other mode of procuring relief seemed to offer much chance of success. The operation has now been often practised in the provinces and in America; Mr. Bryant has performed it twice at Guy's Hospital, and Mr. Maunder once at the London Hospital. These three cases and Mr. Adams's previous four cases have all healed without suppuration.—*Brit. Med. Journal*, July 11, 1874.

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*Deaths from Chloroform.*—A case of this is reported (*Lancet*, July 25, 1874) to have occurred at Addenbrooke's Hospital, Cambridge, England, and another (*ibid.* Aug. 1) at the Royal Infirmary at Leeds.

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*Revival after Poisoning.*—The successful issue of numerous experiments by Dr. R. Böhm, of Dorpat, recorded in the *Centralblatt* (May 2d, 1874), of revivification of animals apparently dead by means of artificial respiration, are worthy of some-

thing more than a passing notice, since they suggest that if artificial respiration, with compression of the thorax in the vicinity of the heart, were fairly carried out in some instances of poisoning in the human subject, equally satisfactory results might be attained. Böhm injected a few grains of potassium salts into the veins of cats, and found that rapid sinking of the blood-pressure and arrest of the heart's action took place. The breathing soon ceased also, and the animal died in convulsions. If now within a certain time, which Böhm found must be within eight minutes from the stoppage of the respiration, artificial respiration and rhythmical compression of the thorax were gently but effectively performed, the heart suddenly, though sometimes not till after the lapse of *forty* minutes, began to contract regularly, and the tension of the blood in the vessels, which had previously fallen to zero, soon rose, and, after a short space of time, often considerably exceeded its normal amount. Spontaneous respiration recommenced in from three to five minutes after the heart had awakened to renewed activity. In from three to ten minutes after this, reflex excitability was observed, and the animal then rapidly woke up as if nothing had happened to it. The experiments failed if too long a time had been allowed to elapse before the artificial respiration and compression of the thorax was commenced. These facts place in a new light the excitability of the heart of warm-blooded animals, showing that the apparently dead animal may be resuscitated even when so long a period as forty minutes had elapsed from the time of the total absence of contraction in the heart. As in all the experiments the blood-pressure was measured, it was satisfactorily demonstrated that the compression of the thorax produced on each occasion a rise varying from 30 mm. to 60 mm. of mercury, even when the arterial circulation had almost absolutely stopped and its pressure was reduced to zero. In a practical point of view it is of special importance to note that artificial respiration (through the canula of the trachea) was never sufficient for resuscitation; it was in all instances necessary to superadd compression of the heart. It is difficult to say whether the recovery in these cases was due to the mechanical excitation of the heart or to the slight movement of the blood shown by the manometer to take place. At any rate, it seems to afford a valuable hint that, in cases of poisoning by volatile agents, or by materials which are decomposed in the circulation, artificial respiration is not the only means to be relied on, but that this should be supplemented by firm pressure on the thorax, which may be effected either by the person who is performing the artificial respiration or by an assistant.—*Lancet*, June 13, 1874.

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*Spontaneous Generation.*—M. Onimus has again been occupying himself with the subject of spontaneous generation, and at the last meeting of the Société de Biologie de Paris brought forward a new apparatus with the aid of which he has been enabled to trace the formation of bacteria, even when, as he believes, the admission of germs, supposed by Pasteur to be floating in the air, was completely prevented. The apparatus in question consists of a flask with three tubules, in which a vacuum is made by filling it with water, which is again expelled by prolonged ebullition. One of the needles ends in a hollow needle, and this is made to penetrate either the heart of a living rabbit or the interior of an egg. On the cooling of the flask several grammes of the blood of the animal, or of the albumen of the egg, are sucked up into its interior. Air is then allowed to enter the flask, but only after filtration through a thick layer of cotton-wool. M. Onimus then finds that, after the lapse of a day or two, molecular granules make their appearance, and soon afterwards vibrios and bacteria are visible.—*Lancet*, June 13, 1874.

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*University of Edinburgh.*—Professor J. Hughes Bennet has resigned the professorship of Institutes of Medicine in this University, which he has held for the last twenty-six years.

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HENRY C. LEA, Philadelphia.

SUPPLEMENT TO

# THE MEDICAL NEWS AND LIBRARY.

No. 381. (*For List of Contents see last page.*) September, 1874.

## Anatomy and Physiology.

### *Anatomy of the Kidney.*

R. Haidenhain (*Schultze's Archiv*, vol. 10, part 1) has made some discoveries in the epithelial lining of the uriniferous tubules, which promise to be of considerable importance. He alludes incidentally to the disputed question of the epithelial covering of the Malpighian corpuscles, and states that he has found not only the covering, but, further, epithelial cells among the vascular convolutions. Before discussing his discoveries in the tubules, it may not be amiss to describe, briefly, the changes in size and shape which they undergo in their course. After leaving the Malpighian bodies, they are comparatively large and convoluted; then, becoming much smaller, they run down towards the pelvis of the kidney and return again to the periphery, thus forming "Henle's loops," of which the second or ascending half is the larger in diameter. Next comes a short, dilated, "intercallated" portion, which resembles a piece of the convoluted portion, and empties into the straight tubes which constitute the beginning of the end. The epithelium of the convoluted tubules is very peculiar, inasmuch as it does not consist of separate cells, but of a continuous pulpy mass, in which nuclei are imbedded at pretty regular intervals, together with fat globules and granules. The important part of Haidenhain's discovery is that the epithelial layer of these convoluted tubules is full of little rods pointing to the centre of the cavity and separated from one another by a homogeneous ground substance. Under the influence of certain reagents, nuclei appear among the rods. The author accounts for these appearances as follows: "The protoplasm of the cells which originally lined the convoluted tubules is for the most part devoted to the formation of the rods, between which a small amount of connective tissue (kittsubstanz) remains as a residue of the original formative material. The nucleus is, in all cases, surrounded by a greater residue of undifferentiated protoplasm, which, in some cases, is definitely limited externally, and in others passes without sharp limits into the substance surrounding the rods." The rods cease with the convoluted tubules, and the first half of "Henle's loop" presents the usually described lining of epithelial cells, with prominent nuclei, but the rods reappear in the larger or ascending half of the loop, and continue through the "intercalated" portion to the beginning of the straight tubules. The rods were found to a greater or less extent in the kidneys of animals of various classes, but with such apparent irregularity that no clue to their function could be gained by comparative anatomy. Haidenhain appears to have proved, by certain physiological experiments, that the process of excretion in the kidney is not confined to the Malpighian bodies, but, with praiseworthy caution, he offers no theory as to the function of the rods.—*Boston Med. and Surg. Journal*, March 12, 1874.

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### *Accessory Pulmonary Lobe of the Vena Azygos.*

Dr. E. W. Collins laid before the Pathological Society of Dublin (*Irish Hospital Gazette*, April 1, 1874) a specimen illustrating this rare congenital condition, taken from the body of a male subject, aged about 50 years, in the

adjacent dissecting-room. The specimen presented a threefold morphological peculiarity as regarded lung, pleura, and azygos vein. An accessory lobe, measuring four inches in length by two and a half in breadth at its widest portion, sprang from the angle between the root and the upper portion of the right lung, immediately above the bronchus. It was somewhat pyriform in shape, and rested upon the right side and front of the bodies of the five upper dorsal vertebræ, in an accessory pleural pouch. The pouch was formed by a duplicature, which depended from the cone of the pleura. It was continuous with the costal pleura externally along a line corresponding to the heads of the five upper ribs, internally along the mesial line of the five upper dorsal vertebræ. Between these points it arched over the accessory lobe, and isolated it from the remainder of the lung. It extended underneath the trachea, and invested the right side of the œsophagus. The azygos vein, instead of arching over the bronchus, arched over the peduncle of the accessory lobe, lying in the lower free margin of the pleural duplicature. Dr. Collins remarked that this was the only specimen of the kind that had been exhibited or noticed in Dublin; and was worthy of the attention of anatomists, as records of only seven similar cases were extant. The question naturally presented itself, was there a necessary mutual relation between the abnormal conditions of the three structures? In explanation, reference was made to the changes which take place in the direction of the vena azygos during fœtal life, stress being laid upon the admirable suggestion of Prof. Cleland, that an abnormal course of the vein during the process of its development, whereby it drew down around it a pleural fold, and thus isolated a probably adherent portion of the lung, offered a sufficiently satisfactory solution of the difficulty. Dr. Collins pointed out that a remarkable confirmation of this theory was to be found in an unique recorded case, hitherto unnoticed in this connection, of a similarly situated accessory lobe of the left lung, where the left azygos vein preserved its fœtal condition by opening into the left vena innominata. Lastly, the more frequent occurrence of the threefold abnormality upon the right side was readily explicable; for, the persistence of the cardinal vein retaining its original connection with the duct of Cuvier, while the normal arrangement upon the right side of the body, upon the left side was far from frequent.

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*Case of Siren-like Malformed Fœtus at Full Time, with a well-formed Penis on the Posterior Aspect of the Body.*

Mr. William Maclaren reports (*Edinb. Med. and Surg. Journ.*, Jan. 1874) the following interesting case:—

Early on the morning of the 16th October I was called to attend Mrs. B. in her ninth labour. On reaching the house I found that labour had been progressing steadily for some few hours previously, and on examination found the head in the vulva, and every prospect of the child being born in one or two pains, which was the case. On delivery the child was alive, but soon died. The placenta had undergone considerable fatty degeneration, and was very friable. Considerable hemorrhage followed the expulsion of the placenta, but was soon controlled, and the mother has done well.

Remarks on the Fœtus.

*Measurements.*

| | |
|---|---|
| Occ. front | 13⅜ in. |
| Extreme length | 18 " |
| Girth of chest | 12¼ " |
| Weight | 4 lbs. 10 oz. 6 dr. imp. |
| Girth of pelvis | 10 in. |

From the pelvis downwards both limbs are fused into one pyramidal mass, bifurcating into a fan-shaped arrangement of the feet, the soles pointing anteriorly, and surmounted by three toes on each side of the central line, one in the middle, and one about a line behind, in the dorsum of the mass. Anteriorly, at the junction of the abdomen with the lower extremities, two inches below the

umbilicus and exactly in the mesial line, is a small papular nodule of skin, without any opening.

*At a corresponding point posteriorly, and 1½ inches below the coccyx, hangs, like a caudal appendage, a well-formed penis, with a pervious canal, without any trace of scrotum, testis, or anus.*

The nates may also be said to be absent. The limbs are joined together in their inner and posterior aspects, so that both patellæ are found on the outer side quite movable. The hip-joints move freely antero-posteriorly only. The knee-joints are indistinctly mobile, and the ankle-joints less so. The nails on the fingers are well developed, fully so on the great toes, and becoming less distinct as they diminish in size. The upper part of the body is, both in measurement and appearance, natural. It is interesting to note that the eldest child of this woman, who lived for twelve years, had a patent foramen ovale.

The specimen has been sent to the Anatomical Museum of the University of Edinburgh.

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### *On Coughing.*

Dr. O. Kohts (Virchow's *Archiv*, vol. lx. Heft 2, p. 191), for his experiments upon this subject, used cats and dogs. Neither the position of the glottis nor diaphragm was directly observed; the author, like Nothnagel, drawing his conclusions from the occurrence or non-occurrence of the characteristic detonations during coughing. The animals were in no case narcotized. For the production of coughing the author employed mechanical stimulants, feathers, pinching, teasing, squeezing with forceps; chemical irritants (common salt and ammonia), thermal (ice), and electrical stimulants. From his experiments the author draws the following conclusions. By stimulation of the centripetal fibres of the pneumogastric nerve, reflex coughs are produced, and this is proved experimentally:—

1. For the trunks of the pharyngeal and superior laryngeal nerves of the pneumogastric:

2. For the peripheral endings of the pneumogastric nerve in the following areas. Coughing occurred:

(1) On stimulation of the mucous membrane of the pharynx, of the larynx (of the fossa interarytænoidea, of the plica glosso-epiglottica and plicæ aryepiglotticæ), of the trachea, of the bifurcation of the trachea, and of the bronchi:

(2) On stimulation of the costal pleura:

(3) On stimulation of the œsophagus (the experimental proof for a so-called stomach-cough is wanting).

3. There is a central cough which can be produced by direct stimulation of the medulla oblongata (*vagus*).—*London Med. Record*, July 15, 1874.

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## Materia Medica and Therapeutics.

### *On the Mode of Action of Iodine and its Preparations.*

In the previous number of this Journal we published a portion of a lecture by Professor Sée on the Action of Iodine. In that part, the mode in which it reached the blood was mainly discussed; in the present, its effects after reaching that fluid are chiefly considered.

Chemistry has taught us nothing touching the action of iodine on the blood: it is neither plastifying nor liquefying; moreover, the blood is not the medium in which the principal phenomena take place. This liquid, according to Claude Bernard, is merely a medium in which the organs live. The corpuscles constitute all that is alive in the blood; and in designating the latter "liquid flesh" certain *savants* have given a definition more poetic than scientific. The inter-

changes of the gases introduced and expelled by respiration are entirely physical phenomena, which do not in any way prove that the blood is a living substance, excepting of course its corpuscular element. From this Professor Sée concludes that iodine does not act on the blood, or, if it does, its effects are difficult to be demonstrated—at least clinically.

*Action on the Circulation.*—The circulation is manifestly modified by the administration of iodine. The beats of the heart are accelerated, particularly if the pulse be calm; and this effect is produced, whatever be the dose employed. If the pulse is already frequent, it will not be accelerated to a remarkable degree. These facts have been brought to light by the regretted M. Kuss, of Strasburg, by whose death science has sustained a great loss; but in asserting that in giving the iodine in considerable quantity no untoward effect was produced, he did not explain the cause of this singularity. The explanation is found in the rapid elimination of the drug whilst the circulation of the blood is accelerated. M. Sée therefore concludes, with Puche, that in certain individuals enormous doses must be administered to produce the desired effect, instead of small doses that are so timidly prescribed. In varying the dose of the iodide of potassium according to individual cases, we shall soon find out that the small dose of one gramme (about sixteen grains) a day produces as much an effect as that of three grammes. Here not only is the general circulation accelerated, but hyperæmia of all the organs takes place—the skin is covered with papules, erythema, acneform pimples; sometimes the skin and subjacent cellular tissue are congested and become the seat of a sort of œdema, which is principally visible in the eyelids; the conjunctiva is injected, which may be followed by ophthalmia; the mucous membrane of the throat is also affected; the pharynx and tongue are swollen, as also are the mucous membrane of the larynx and probably that of the bronchi, followed in some cases by dyspnœa and catarrh; even the expectoration may be sanguinolent; the mucous membrane of the stomach is excited; the functions of the uterus are modified, or rather exaggerated, resulting in menorrhagia—hence the utility of iodine in amenorrhœa and dysmenorrhœa. These divers phenomena of congestion have been described as the commencement of iodism; but M. Sée looks upon them as the physiological effects of the drug, and that they are not particularly due to large doses, in proof of which he states that after having swallowed two grains of the iodide of potassium, and even less, all the symptoms of iodism may be observed; and this dose is certainly not toxic. The phenomena of iodism under these circumstances are temporary, but the patient should always be warned of their possible occurrence. If, on the other hand, large doses are at once administered, we shall not have iodism, but poisoning by iodine. Such cases are not numerous, but some are known to have occurred, and among others the death of a young German lady, who was treated and killed by her countryman Dr. Rose. This practitioner injected iodine into an ovarian cyst of which the patient was the subject; this was followed by serious consequences. He described minutely, and by the hour, the tragic scene that was taking place. As soon as the injection was practised, a convulsive spasm of the arteries followed; the pulse, hardly perceptible, was very frequent; the heart beat violently; the patient became cyanosed and felt a sensation of intense local cold. The spasm lasted sixty hours, after which the patient became red, the arteries were relaxed, the heart beat feebly, and death occurred on the fourth day. There was no increase of temperature, from which it may be inferred that there was no iodic fever as affirmed by Dr. Rose. Such are the symptoms of poisoning by iodine, which, it may be seen, do not resemble those previously described.

*Action on Innervation.*—Whatsoever the dose of iodine absorbed, the patient experiences frontal headache and even well-marked neuralgia of the trifacial nerve. The cephalalgia is due to coryza, the neuralgia of the trifacial nerve to congestion of the sinuses. But besides these nervous phenomena there are others which are known under the name of iodic intoxication, characterized by giddiness, hallucinations, trembling; these are disturbances of the circulation. During the giddiness there is contraction of the arteries, as in the case of Dr. Rose's young patient; this is already the commencement of

poisoning. According to M. Sée the nervous system is at first modified only in its circulation; but when strong doses of the iodine are administered, short of poisoning, the nervous substance is affected. From this it may be inferred that iodine indirectly favours regeneration, the re-constitution of the tissues, particularly the nervous elements.

*Elimination of Iodine.*—Iodine is easily eliminated, and appears in the urine, the saliva, and that soon after it has been ingested; but traces of the drug are still found in these secretions several weeks after the patient had discontinued it. In its elimination, iodine modifies the textures of the organs through which it passes—kidneys, skin, mucous membranes. But its action is complex, and it is very possible that the local hyperæmiæ it determines are only due to the passage of the iodine; and, in fact, these congestions are almost distinct from the modifications of the general circulation. A patient, for instance, takes a dose of iodide of potassium at ten o'clock, at eleven his conjunctivæ are congested and the lachrymal secretion is increased. It may be that this congestion is the effect of the passage of the iodine, which is deposited on the mucous surface, and there produces irritation caused by its direct application; we have therefore to consider the direct action of iodine on mucous membranes, and another action, more general and more powerful, which sometimes produces deep inflammation. This can be shown for the mucous membrane of the stomach. If two individuals take iodide of potassium, one may feel none the worse, whereas the other loses his appetite, has a metallic taste in his mouth, and falls off in flesh. Why should there be this difference? The simple contact of the iodine causes an increased secretion of the gastric juice. The iodine is absorbed, then eliminated by the stomach; and according as the latter is more or less deeply attacked, the appetite will be more or less affected. Unfortunately, one cannot foresee how it will act, but we should not forget that in small doses iodine is often appetitive, because it increases the secretion of the gastric juice. We should, however, remember that the elimination in the stomach takes place through the peptic glands, and that in its passage the iodine destroys a certain number of these latter. This action of elimination may produce evil consequences, and the greatest circumspection is therefore necessary in the employment of this heroic but dangerous remedy.

The iodide of potassium has been prescribed to stop the vomiting of pregnant women, but for this it is not equal to alcohol nor to the bromide of potassium.

The iodide of potassium has a certain action on the kidneys; it may produce nephritis, destroy the tubuli uriniferi, and produce albumen in the urine; but all metals do this, so we cannot make a special complaint against iodine in this respect. This leads us to the study of the composition of the urine in individuals who take iodine, which will enable us to give the drug its proper place in the therapeutic *cadre*. If the effete matter of the organism, or the urea, be diminished during the use of iodine, it is because this latter is a substance that prevents the waste of the tissues (*medicament d' épargne*). Such was the conclusion arrived at by M. Rabuteau, who, in his experiments, found a diminution of urea; but it may be objected that these experiments are not absolutely rigorous. M. Rabuteau subjected himself to a certain diet for five days; he measured the quantity of urea which he excreted each day, and found twenty-eight grammes as the mean; on the fifth day he took iodine, and found no more than twenty-four grammes of urea in his urine. The experiment ought to have been more precise. M. Rabuteau ought not only to have weighed the ingesta, but he ought to have ascertained the quantity of nitrogen; he should then have measured the quantity of nitrogen eliminated by the different outlets. When the balance between the nitrogen absorbed and that eliminated is properly ascertained, it is only then that one can fairly estimate the results produced by a particular drug or any other substance. This is what was done by M. Beck in the case of a syphilitic patient; the results of this observation were negative, and the deduction was that iodine does not act on the composition and decomposition of the tissues. But M. Bouchard declares, on the contrary, that, according to his own personal experience, iodine increases the quantity of urea excreted daily, particularly in diabetics. The natural conclusion is that iodine is not a destructor of the economy. Professor Sée protests against the

conclusions of M. Bouchard, and brings clinical proofs against the arguments of the latter gentlemen. Diabetics, continued the Professor, do excrete more urea than a person in health. According to the learned Professor, it was not the iodine absorbed that manufactured the excess of urea; it found it in the economy, and it did no more than eliminate the urea, just in the same way that it draws away all that it meets with in its course. If in syphilitics it meets with mercury, the iodine favours its expulsion in forming an iodo-mercuro-albuminate; if, on the other hand, the mercury is combined with the blood, muscles, bones, or nervous tissue, the iodine, in regenerating all the vitiated molecles, expels the mercury indirectly by the formation of new elements. The following is a summary of the therapeutic applications of iodine:—

It is employed to eliminate all the poisons which may impregnate the economy —syphilis, mercury; it has also been employed as an eliminative in gilders' and lead poisoning, and in arsenicophage.

The mucous and serous membranes are modified by iodine, and it is given in asthma, albuminuria, ascites, pleurisy, etc. It is employed as a "dissolvant" in glandular swellings, and it produces excellent effects on goitre; but it also exercises a certain influence on the breasts and testicles, which it atrophies. It is useful in a great number of chronic affections by dissolving certain products which it eliminates; thus it is employed in diabetes, scrofula, syphilis, etc.

In fine, iodine is a most useful drug, but it is a two-edged instrument, difficult to deal with. It is a local "atrophiant;" it has no ill effects on the general health; it is a "*revivificateur*," like oxygen.—*Med. Times and Gaz.*, April 18, 1874.

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### *The Physiological Action of Apomorphia.*

Max Quehl, in an inaugural dissertation (*Medicinische-Chirurgische Rundschau*, Heft ii., 1874), gives the results of a series of experiments he has performed, under the guidance of Professor Köhler, on the effects of apomorphia-muriate upon frogs and dogs, the alkaloid being applied partly in the form of powder, and partly in a solution containing 1 : 50 parts of water. He finds that when subcutaneously injected, which is the best method of administration on account of the small amount of irritation it excites, vomiting is caused in dogs by a dose not exceeding ½ to 2 milligrammes; in man, from 6 to 7 milligrammes are requisite. When given by the mouth in dogs, 3 to 4 centigrammes constitute a certain dose, but 1 centigramme is uncertain. In the case of man, 12 to 18 centigrammes are required to produce the effect with certainty. When introduced per anum, 6 centigrammes are required in the case of the dog, and in man from 18 to 36. Placed upon the tongue from 1 to 2 centigrammes are required for dogs. Infrication of apomorphia ointment into the skin of the inner side of the thigh, and the introduction of plugs with apomorphia ointment smeared over them, into the vagina, had no action. The experiments upon the effects of the introduction of large doses of apomorphia, 1½ to 6 grains subcutaneously, gave interesting results. No vomiting followed them, but the drug had a narcotic effect. The animals performed the movements of manège and running round in a circle; there were reduction of reflex excitability and paresis of the hind legs. The pupil was frequently dilated and, as a subseqnent effect, loss of appetite, which remained for two days, and general depression. Death did not occur in any case, even when large doses were administered. The effects, after moderate emetic doses, upon the pulse, temperature, and respiration, as observed by Quehl, agree precisely with those observed by Siebert. Nutrition underwent no change; so that an animal made to vomit once daily at least by means of amorphia for at least several weeks, exhibited an increase of 2½ lbs. In regard to the action of apomorphia upon the nervous and muscular systems, and upon the circulation, Quehl thus sums up his results: 1. Apomorphia affects neither the motor nor the sensory nerves. 2. After section of the vagus, its emetic effect ceases. 3. The curve of the muscles in contraction is not in any way modified in the case of the frog. 4. There is no evidence of influence upon the vaso-motor nerves, nor of any paralyzing influence upon the reflex action of the sensory nerves upon the vaso-

motor centre through the spinal cord. The main conclusion to be drawn from the whole of the experiments is, that apomorphia in small doses is to be regarded as the best and least dangerous of all emetics. In the discussion at the Leipsic Society of Natural Sciences, after the reading of the paper, Mosler stated that he agreed with the author in regard to the emetic properties of apomorphia in fresh solution, but that he had found that when the solutions were five or six days old the phenomena of intoxication with the drug occurred. Köhler stated that he had found that after some weeks, though the solution had acquired an intense emerald-green colour, it yet had lost little of its activity. Riegel, who had made upwards of seven hundred experiments with apomorphia, said that he did not regard it as very decomposable, and that, in opposition to Quehl, he had noticed vomiting after section of the vagus. The vomiting, he thought, must be explained on the idea of the action of the drug on the central nervous system, since, after a series of sections of the spinal cord, he at length arrived at a plane, after which no vomiting follows.—*Practitioner*, June, 1874.

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### *On the Physiological Action of Hydrocyanic Acid, and the Pretended Antagonism of Hydrocyanic Acid and Atropia.*

Preyer affirmed that atropia was a certain antidote to hydrocyanic acid (*Die Blausäure physiologische übersucht*, Bonn, 1868–1870). Prof. R. Boehm and A. Knie (*Archiv für Experimentalle Pathologie und Pharmakologie*, Band ii.), from their experiments, show that Preyer's affirmation is incorrect. They experimented for the most part on cats, which were often narcotized with chloral, which they recommend for this purpose. In all experiments tracheotomy was performed. Pryer employed almost exclusively rabbits. The hydrocyanic acid employed was the officinal, containing 2 per cent. It was always injected into the jugular vein. Preyer applied the drug to wounds, or to the mucous membrane, or injected it into the subcutaneous tissue, or let the animal respire it. The drug is most active when injected direct into the veins, and next to this comes inhalation.

The authors then criticize Preyer's experiments, and from their own investigations arrive at the following results:—

1. Hydrocyanic acid acts on the central nervous system, the functions of which are abolished by large doses after stimulation, *i. e.*, increase, of short duration. 2. The disturbances of respiration and circulation arise from analogous changes in the activity of their centres in the medulla oblongata. 3. The vagus does not play a part either by the action of hydrocyanic acid on the respiration, or by that on the heart. 4. Atropia is no antidote for hydrocyanic acid; the only rational method for the treatment of poisoning by this consists in the application of artificial respiration.—*London Med. Record*, July 8, 1874.

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### *Bromide of Camphor.*

At the last sitting of the Société de Biologie Dr. Bourneville made a most interesting communication on the physiological action of the bromide of camphor ($C_{10}H_{16}OBr$). From his various experiments, conducted on guinea-pigs and on cats by the hypodermic method, he draws the following conclusions: 1. Diminution in the number of cardiac pulsations. 2. Diminution in the number of inspirations. 3. Fall of temperature (in a cat of three months which had received ten grains of the bromide, the temperature fell from 38° C. to 21° in seventy-one hours). The sedative properties of bromide of camphor are also shown by other phenomena. The animals to which such small doses as two or four grains of the substance were administered, fell into a state of marked torpor, which, under the influence of stronger doses, became so profound as to lead the experimenter to think that the animals were dead. When taken up in the hands they were motionless and flabby. A violent pinch would wake them, showing that sensibility was not abolished. In both kinds of animals, during the whole duration of fall of temperature and torpidity, only

slight tremulation was observed; but when the temperature rose and the animals awoke, convulsions supervened, but only in the cats. According to Dr. Bourneville the animals did not soon get accustomed to the drug. Another interesting fact which he mentioned was the speedy loss of flesh under the influence of the drug. Dr. Bourneville wound up by asserting that bromide of camphor was a most powerful sedative.—*Lancet*, June 20, 1874.

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*Antiseptic, Antifermentative, and Disinfectant Properties of Perchloride of Iron.*

The following is a *résumé* of these properties, discovered by the eminent chemist Carlo Paresi:—

1. Meat, fish, etc., immersed in a dilute solution of perchloride of iron, are preserved without putrefaction. Removed from the bath and dried in the air, they assume a stony hardness, and become slightly brown and inodorous.

2. The addition of a small quantity of perchloride of iron to cow's milk causes the immediate separation of the caseine in the form of a flaky magma; and, exposed to the air, the caseine, the butter, and the serum, are exempt from decomposition, even after the lapse of a considerable time.

3. The addition of a small quantity of perchloride of iron to urine causes a white precipitate. Exposed to the air at the ordinary temperature, even for a considerable time, there is no development of ammonia from the urea, and the urine remains inodorous.

4. Blood recently drawn from the veins, to which the iron is added, immediately forms a compact clot, and, exposed to the air, is preserved without putrefactive fermentation.

5. The seeds of the ceralia immersed for twelve hours in a solution of perchloride of iron, and afterward planted, do not germinate.

6. The addition of ammonia in excess to the solution of perchloride of iron causes the precipitation of peroxide of iron, with the immediate disappearance of the ammoniacal odor. Here, besides the precipitate of the peroxide of iron, chloride of ammonia is also formed and remains in solution. The excess of ammonia is no longer perceptible, in consequence of the *sui generis* disinfecting action of the perchloride of iron.

7. The sulphate of potassa, dissolved in water, immediately presents a yellowish-red precipitate, on the addition of perchloride of iron, and the odor of the hydro-sulphuric-acid gas disappears.

8. A solution of perchloride of iron, poured on to paper amidorized with iodide of potash, produces a blue color at once. Paper saturated with tincture of guaiac, to which it is added, immediately assumes the characteristic azure tinge. "If we are not deceived, these reactions are produced by ozone, which exerts a great hygienic influence on the animal organism in all those contingencies in which the air is contaminated with parasites, deleterious gases, and miasmatic emanations."

9. Mustard or bitter almonds, reduced to a liquid paste with perchloride of iron, are prevented from forming the essential oils characteristic of these substances.

10. The solution of perchloride of iron mixed with wheat flour and yeast prevents the bread-fermentation; with the must of grapes, the vinous fermentation; and with sugar or honey, the alcoholic fermentation.

11. Finally, perchloride of iron placed in contact with metallic mercury, and properly rubbed in a marble mortar, is rapidly reduced into minute particles of a bluish colour; to this is added axiunge, and the rubbing continued for about a quarter of an hour An extremely well-prepared mercurial ointment in which, even with a strong glass, no particle of metallic mercury can be seen, is thus obtained. The iron may be washed out with water.—*N. Y. Med. Journ.*, June, 1874, from *La Nuova Liguria Medica*, February 20, 1873.

*On Carbolized Resin-Cloth.*

As an antiseptic dressing, Mr. LUND recommends the use of a carbolized resin-cloth in the place of the ordinary cerecloth, the effect of the addition of resin being to neutralize the acrid properties of the carbolic acid, which still evolves an antiseptic vapour at the temperature of the body. He uses a very thin calico gauze, and the solution for its saturation is prepared as follows (*British Medical Journal*, December 6, p. 654):—

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| Carbolic acid crystals (melted). . . . | 2 fluidounces. |
| Castor oil . . . . . | 2 fluidounces. |
| Purified resin . . . . . | 16 ounces. |
| Methylated spirit . . . . . | 40 fluidounces. |

To the resin liquefied by heat and removed from the fire is added one-third of the spirit; when these are well mixed, another third of the spirit in which the oil has been previously dissolved is poured in; and lastly the acid dissolved in the remainder of the spirit is slowly added. The whole must be agitated until all the ingredients are thoroughly incorporated and afterwards passed through a muslin filter to get rid of extraneous matters. If this plan be not adopted, the resin will concrete into a mass at the bottom of the vessel, and it will be extremely difficult afterwards to get it perfectly mixed. Thus prepared, the solution is of a dark colour, clear, and free from any deposit, and can be kept unchanged for a long time in a well-corked bottle. The castor-oil is added that the cloth may retain its flexibility after the evaporation of the spirit.

To prepare the resin-cloth a very cheap, thin, porous calico, or calico-muslin, is selected, known in the trade as "mulls;" it should be unbleached, and free from dressing. This is divided into strips of about nine inches wide, and six yards long. The strips are carefully folded so as to lie flatly in a tin box, made so as to receive the plates of a tincture press, or an ordinary copying press, and having an aperture at the bottom of the box, with a tap so that the superfluous fluid can be removed and reused. The solution is poured over every layer of cloth successively, so as to wet every portion of it; next the pressure is applied, and the calico squeezed as dry as possible, then taken out and hung for a few hours in a well-ventilated, warm room, till all traces of smell of methylated spirit have departed. The cloth may afterwards be rolled up and kept in tin cases ready for use. It appears to be necessary to dry it thoroughly, as the presence of any traces of the methylated spirit is apt to cause irritation.—*London Med. Record*, April 8, 1874.

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## Medicine.

*Dengue.*

Dr. H. C. D'AQUIN contributes to the *New Orleans Med. and Surg. Journ.*, July, 1874, a short paper on dengue. He defines it to be a fever with two paroxysms, separated by a short remission, and lasting five full days.

The first paroxysm, *period of invasion*, sets in abruptly with a high temperature, the exact degree of which could not be ascertained, on account of the difficulty of seeing the patient at the very moment of the invasion. The *defervescence* that terminates this period, is either slow, or rapid, and ends in a period of calm, or *remission* of short duration, which is immediately followed by a quick, or a lingering rise—*effervescence*, terminating by a high temperature the acme of the second paroxysm or *exacerbation*. The second defervescence, which is generally lytic, without, or with very small evening rises, comes after, and terminates the disease by a fall to the normal point, in the early part of the

morning that follows five complete twenty-four hours. which is generally the morning of the sixth day, or the seventh when invasion took place after mid-day on the first day.

An eruption which could not be detected in all the cases, mixed as it were with lichen agrius and other eruptions, the product of excessive summer heat, appears at the very fastigium of the invasion, follows it through all its periods, becoming paler during first defervescence and remission, stronger marked during effervescence and fastigium of exacerbation, disappearing, and desquamation taking place during and after second defervescence.

Observations of the temperature during the course of the disease show :—

1st. That the remission between the two high temperatures rarely comes to the normal point, but stops at a few tenths of a degree above or below 38° Cent , 100.4° Fahr., not being a period of apyrexia, but a diminution of heat of short duration.

2d. That the remission does not always fall on the same days, but sometimes on the third or on the fourth day.

3d. That the exacerbation shows a high peak also on different days, on the third, the fourth, and even the fifth.

4th. That notwithstanding this fall of remission and exacerbation on different days, the disease completes its evolution in five times twenty-four hours, in nearly all the cases ; the time of the excursus of the effervescence and defervescence constituting the paroxysms, being longer or shorter, in order to compensate the time of the complete evolution of the disease.

5th. That each of the paroxysms lasts separately from forty-eight hours to three days and a half; but that the time of their evolution is not generally the same.

6th. That the pulse follows faithfully the rise and fall of the temperature, throughout all the periods, the two lines being parallel mostly all the time.

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### *On Tertiary Syphilis.*

Fournier (*La France Médicale*, May 23, and June 3, 1874) defines tertiary syphilis to be that group of manifestations which is developed when a long interval has elapsed since contagion. He says the natural tendency of syphilis is to reach the tertiary period, though it is not of necessity attained by all the affected. He believes the following reasons to explain why some individuals are attacked more than others. 1st. The conditions peculiar to the individual, such as weakness of constitution, scrofula, lymphatic or anæmic conditions, chronic alcoholism, old age, and any depressing cause, though they have a certain predisposing power, may not unfrequently be all absent and yet the disease may be developed. 2d. A far more potent cause of tertiary affections is absence or insufficiency of treatment in the early period of the disease. Throughout his paper Fournier insists upon the disastrous effects produced by "expectant" or "simple" treatment of syphilis. In attempting to distinguish between the periods of secondary and tertiary affections respectively, Fournier acknowledges the impossibility of laying down a hard and fast line between the two periods. The disease passes from the earlier to the later stages in one of two ways. In one, the phenomena gradually change from one form to the other, or the later ones appear before the earlier forms have wholly disappeared. In the other, a more habitual one, there is an interval of quiescence before the tertiary affections break out. As a general rule, tertiaries are rare before the second or third year, while the interval may be prolonged frequently for ten to twenty years; and Fournier relates a case from his own experience where the tertiary period had continued fifty-five years after infection. The general character of the tertiary period is one of full health interrupted by morbid phenomena, which have no stated period for their appearance, but may occur and recur during many years, indeed, while life lasts. When present they are scattered, even isolated or solitary, while no part of the body is exempt; their outset is insidious, their development slow, and in many latent. Their anatomical seat is the parenchyma of the tissue attacked, the deeper structures rather than the superficial part. Thus they destroy the tissue or organ in

which they are developed. They set up two kinds of tissue-change; one, inflammatory fibrous increase and contraction of the parenchyma; the other, the gummy tissue peculiar to syphilis. Lastly, tertiary syphilides are almost always curable.

In establishing the diagnosis of tertiary syphilis, attention must be paid to three points: 1. Special characters; 2. Coexistence of specific affections elsewhere; 3. Previous syphilitic affections. But any of these conditions may be wanting, and render the diagnosis often dependent on two or even one of the others. With regard to the special character of the affection, unfortunately tertiary syphilitic affections more often want special characters than possess them. Most frequently, again, the affection is isolated, the sole one present. Again, the history of previous syphilis is most commonly wanting, in women as often as in one out of four or five cases. Former syphilis is often forgotten or not suspected, on account of the length of time that has elapsed, and the determination of some patients to deny any fact which casts a slur on their moral conduct. This obstinacy, combined with the social reputation of the patient, sometimes puts the questioner off his guard. All these circumstances impede the practitioner in reaching a true diagnosis.

The prognosis of tertiary syphilis is always serious, often grave, and more often fatal than is generally believed. It is influenced by position and by the condition of the patient. Nevertheless, speaking generally, tertiary affections are eminently curable (*i. e.* the lesions, not the diathesis). Though the iodides alone, or combined with mercury, are the remedy *par excellence*, there are cases in which both these remedies fail. For example, over the inflammatory changes produced in an organ by the irritating presence of the syphilitic affection, mercury and iodine have little or no influence. In conclusion, Fournier insisted most strongly on the great importance and possibility of *preventing* tertiaries by a well-sustained and prolonged treatment of syphilis in its early stages. He attributes much of the subsequent disease to the inefficient treatment of the patient during the first two years after infection, and utters a powerful protest against the custom of withholding mercury when the early symptoms begin to abate. At this time, it should be continued steadily for several months after the patient is apparently well.—*London Med. Record*, July 1, 1874.

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*On a Case of Pseudo-hypertrophic Muscular Paralysis.*

Drs. J. Lockhart Clarke and W. R. Gowers reported (*Brit. Med. Journ.*, June 13, 1874) the following case at a late meeting of the Royal Medical and Chirurgical Society.

The case was that of a boy, a patient of Mr. William Adams, who died, aged fourteen, with general muscular atrophy. The muscles of the calf had been, from an early age and until within two or three years of his death, considerably larger than natural. Difficulty in locomotion, due to muscular weakness, had been noticed from the time when he commenced to walk at three years old, and had increased until he had ceased to walk at eight, and to stand at ten. During the last three years of his life, the calves lessened in size to below the normal, and the muscles of the thighs and arms became atrophied. At the time of his death he could not move the hip, knee, or shoulder-joints; he could move the ankle and elbow-joints a little, and the fingers well. There was but slight difference between the two sides. The flexors of the hip and elbow-joints were contracted. There was no affection of mind, or of cranial nerves, or of the sphincters. He died from a low form of pneumonia. After death the muscles showed in various degree the changes, naked eye and microscopic, characteristic of the "pseudo-hypertrophic muscular paralysis" of Duchenne de Boulogne. The gastrocnemii looked like lumps of fat, and, under the microscope, consisted of fat-cells among which still ran some muscular fibres, accompanied by a good deal of connective tissue Many of the fibres were healthy in appearance and size; many were narrower than normal, still preserving, however, their transverse striæ, even when reduced to one-quarter of their normal width. Many fibres were narrower at one place than at another.

Very few fibres, except those greatly reduced in width, presented any granular or fatty degeneration. The deltoid and biceps muscles on each side presented similar changes, but they contained less fat and more fibrous tissue; the brain and medulla oblongata and meninges of cord were healthy; the spinal cord itself presented various changes throughout the cervical, dorsal, and lumbar regions. The most important was disintegration of the gray substance of the anterior, lower, and central portions of each lateral half. In some places this had occurred chiefly around the vessels, but in others it involved extensive areas, especially in the cervical enlargement, the upper part of the lumbar enlargement, and the conus medullaris. About the level of the last dorsal nerves, it had amounted to almost total destruction of the gray matter on each side between the posterior vesicular columns and the intermedio-lateral tract. Other changes were disintegration of nerve-roots, commencing sclerosis of the lateral and posterior columns, destruction of the white commissure in various places, dilatation of vessels, and extravasations. A comparison of the symptoms and of the character of the muscles in this case with those of other cases, left, the authors believed, no doubt of the identity of the disease. The spinal cord changes were much greater than any previously found, the examinations of Charcot and Cohnheim having given negative results, and the changes found by Barth and by Kesteven having been slight.

Dr. Buzzard inquired whether the authors of the paper thought that the circumstance of changes in the spinal cord having been reported absent in most previous cases and present in this, which seemed to be a peculiarly advanced one, threw any doubt upon the correctness of the now generally received opinion that, in cases of muscular atrophy and analogous condition, the central changes preceded and induced those in the muscular system. Dr. Lockhart Clarke thought that the idea of muscular atrophy giving rise to disease of the central nervous system had been disposed of long ago. In the examination of the spinal cords of persons whose legs had been amputated, he had found the nervous matter, especially the cells, changed; but there was nothing in the form of degenerative or necrotic change. The remarks had been confirmed by a writer in the *Archives de Physiologie*. The changes were quite different from those met with in muscular atrophy. Dr. Greenfield said that secondary degeneration of the nervous tissue of the cord was distinctly seen in cases where there had been disease of the brain, with hemiplegia and rigidity of the limbs. There was here degeneration running down the anterior or the posterior column of the cord. This occurred, for instance, in cases of disease of the corpus striatum. Dr. Lockhart Clarke said that the changes here were due to the cerebral disease interfering with the supply of nourishment. In reply to a question from Dr. Sparks, he said that observations had not been made on the temperature of the affected limb. Mr. William Adams believed that in past years a number of cases of the kind, described by Dr. Lockhart Clarke, had been mistaken by orthopædic surgeons, their nature not being understood. The condition was sometimes confounded with infantile paralysis and with spastic contraction.

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### *Albuminuria as a Symptom of the Epileptic Paroxysm.*

It has lately been shown by Dr. Max Huppert that every well-marked fit of epilepsy is succeeded by the appearance of albumen in the patient's urine. The albumen is not found in the urine which is passed just before or during the paroxysm, but in that voided directly after it, and continues to be present for three or four and sometimes for six or eight hours. The more severe the fit, the more abundant the albuminuria; but cases of mere epileptic vertigo may be quite unattended by this phenomenon, unless the attacks follow one another rapidly. The amount of albumen excreted is never large. There may be sufficient, however, to form the ordinary flocculi with heat and nitric acid, but often there is only a white cloudiness or mere opalescence, especially after mild epileptic fits. The largest quantity of albumen is found in the first urine passed after the fit, and the greatest average amount in those patients who have long suffered from severe attacks. Such urine is also remarkable for its clearness

and its increased quantity, and its specific gravity generally ranges from 1018 to 1020.

Of course great care is required in testing for such small amounts of albumen as epileptic urines contain; but Dr. Huppert shows by comparative experiments with aqueous solutions of albumen of known strength, that the heat and nitric acid test is really a delicate one if properly applied. The best plan is to boil half an ounce of the urine, and then to let it cool a little before adding the acid, so as to avoid the reaction of indican, which might otherwise mislead the experimenter. Six or eight drops of concentrated (not fuming) nitric acid are then added, and the whole is allowed to stand for twenty-four hours, as the albumen reaction does not always take place at once. If a deposit of urates occurs after cooling, it is only necessary to heat the liquid a second time, when the urates dissolve and the albumen remains unaltered. There are two other phenomena by which the severer forms of epilepsy are accompanied; the appearance of hyaline cylinders and of spermatozoa in the urine. The cylinders are found in the first or second urine after the fit, but they do not remain present so long as the albumen does. The spermatozoa also occur in the first urine, after severe attacks, and in about a tenth of the cases exist in such numbers that the conclusion is inevitable that a definite although slight ejaculation of semen is coincident with the fit. It probably is due to a direct nerve-irritation—that is, one which bears the same relation to the central nervous centres as the convulsions do. A true seminal emission is not a phenomenon of epilepsy in Dr. Huppert's experience. It is remarkable that red blood-corpuscles are absent from the urine after epileptic attacks of all kinds, or their number if present is so small that it can be considered of no significance. Even where there were subconjunctival petechiæ, Dr. Huppert could not find an increase of red blood-cells in the urine, even with the most careful microscopical examination. White blood-cells, on the other hand, are almost always present. This absence of red corpuscles points to the arteries as the source of albumen in epilepsy, since Liebermeister, Cohnheim, and Hering have shown that venous congestion, even without rupture of bloodvessels, is always accompanied with an abundance of red corpuscles in the urine as soon as albuminuria commences.

Dr. Huppert (whose paper will be found in the last number of Virchow's *Archiv*) mentions in conclusion the curious fact that while the urine of patients with progressive paralysis of the insane, after epileptiform or apoplectiform attacks, agrees with that of epileptics in containing albumen and hyaline casts, it differs from the latter in containing red blood-corpuscles in some quantity, either isolated from one another, or in groups of six to twelve in each. He does not attempt an explanation of this fact, but contents himself with simply recording it.—*Med. Times and Gaz.*, May 23, 1874.

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### *Croup.*

Dr. Roger, in a recent lecture at the Children's Hospital, remarked that there are two species of croup: the true and the false. False croup is not so commonly seen in the hospital as true croup, as the former is comparatively milder, and occurs in infants under two years, before which age they are not admitted. Croup, the lecturer said, is much more prevalent now than when he began the study of medicine thirty or forty years ago; he could not, however, give the reason. In the Hôpital Sainte Eugénie, situated in one of the most populous districts of Paris, there are at least 500 cases annually. The mortality from this affection is in the proportion of four out of every five cases; and in the hospital just named, tracheotomy is performed on two hundred or three hundred subjects annually, most of whom die soon after the operation. In the face of such unfavourable results, the question naturally suggests itself, whether the operation is justifiable. To this, M. Roger replied that, even if we cannot save life, we can always afford temporary relief. But tracheotomy, to be successful in croup, must be performed early; that is, before the disease extends to the bronchial tubes, and before the patient is exhausted. The etiology of croup differs in different cases; and M. Roger believes the disease to be of a specific and contagious character, and that, like all contagious or epidemic

affections, it spares neither age nor sex. But why it should principally attack children between the ages of two and four is inexplicable. It is rarely met with after seven, and still more rarely in adult age. When the disease occurs in adults ("angine couenneuse," or diphtheria) the patients die or recover; but the disease does not extend to the larynx. Tracheotomy rarely succeeds in adults affected with croup. M. Roger does not believe that cold has anything to do in the causation of croup, as it is met with in all seasons; but it is an undoubted fact that the disease is considerably influenced by cold, and this would account for the greater mortality in winter than in summer. As to the nature of the disease, there is much difference of opinion, even among medical men in the same hospital. M. Bouchut, one of the physicians of the Hôpital des Enfants, believes that the disease is purely local at first, and that, if not checked by treatment, it soon affects the entire system, and the patient is carried off, not only from suffocation and its consequences, but from poisoning of the blood. For M. Roger, also of the same hospital, the reverse takes place; that is to say, the general system is first affected by the specific poison, the throat-symptoms being simply the local manifestation. M. Roger then went through the differential diagnosis between this and false croup, and the affections with which each may be confounded. In referring to the treatment, he condemned the practice of administering tartar emetic, particularly in the doses prescribed by M. Bouchut, who does not hesitate to give about five grains of the salt to a child two or three years old. We have, he said, in ipecacuanha sufficient material to produce emesis without the prostration caused by tartar emetic. Tracheotomy, which was formerly but very rarely practised, is now an every-day operation; and the cures thus effected are estimated at twenty to twenty-five per cent.—*British Med. Journ.*, May 9, 1874.

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*On Acute Purulent Inflammation of the Mediastinum in Typhoid Fever.*

Dr. Frantzel, of Berlin, records a fatal case of this very rare complication of typhoid fever, in the *Berliner Klinische Wochenschrift*, of March 2, 1874. A waiter, aged 52, was admitted into the Charité "in the course of the second or third week of the disease." There were no uncommon symptoms; the cardiac dulness was found normal at the first examination; slight dulness existed at the left posterior pulmonary base. The patient was treated with baths. A few days after admission the stools became more frequent and liquid; on the sixth day the strength was manifestly failing, and liquor ferri sesquichloridi, in doses of five drops every two hours, was prescribed, with red wine. In spite of the continuance of the diarrhœa for the next six days, the condition of the patient was not apparently worse on the thirteenth day of his residence in the hospital; the iron was now stopped. Next day a new set of phenomena began. The patient was found to be worse; the pyrexia was increased; there was complaint of sore throat and pain and tenderness in the neck, and the pharynx presented the signs of catarrh. Slight dulness was found at both posterior lung-bases. On the following evening great dyspnœa set in, compelling the erect posture, and preventing sleep. The appearance of the patient next morning was that of extreme orthopnœa and collapse. The countenance was anxious and cyanosed; the respiratory movements were frequent and superficial, with loud groanings and powerful action of the extraordinary muscles of inspiration. The patient complained of pain in the neck—back and front, and of a severe feeling of constriction in the chest. The jugular fossa in the neck was discovered on examination to have completely disappeared, and to be replaced by a soft, somewhat doughy prominence, which extended upwards as far as the lower border of the larynx, and laterally to the outer head of the sterno-mastoid muscles. No other swelling was appreciable about the neck, but all the muscles were tender to the touch. There was a constant and profuse flow of saliva from the mouth; the palate and pharynx were more hyperæmic and swollen than on the previous day; deglutition was not seriously affected. The larynx was apparently healthy. Marked dulness on percussion existed over the manubrium sterni, decreasing in intensity downwards, but reaching the third rib. There was no marked alteration of the pulmonary

signs beyond general feebleness of the respiratory murmur. Fräntzel's diagnosis was phlegmonous inflammation of the pharynx with suppuration of the connective tissues between the deeper cervical muscles, and extension of the process into the mediastinum. Death speedily followed from suffocation.

The results of the post-mortem examination confirmed the accuracy of the diagnosis. The subcutaneous and intermuscular connective tissue of the front of the neck was found highly œdematous. The swelling was continued into the connective tissue of the anterior and posterior mediastina, and the exudation here was more opaque and in places even distinctly purulent. The trachea in its whole length was firmly compressed from before backwards. The mucous membrane of the pharynx and œsophagus was swollen, hyperæmic, and soaked with semi-purulent fluid. The laryngeal mucous membrane was not œdematous, but on the right side of the epiglottis, on the upper border, was found a shallow, rather elongated ulcer. The other viscera presented the appearances usually found in typhoid fever.

Dr. Fräntzel remarks that this is the first instance on record in which typhoid fever has been complicated with fatal mediastinitis. The inflammation of the connective tissue in this situation was manifestly an extension of the phlegmonous pharyngitis, but it is not so easy to account for the development of the latter disease. The author himself believes that it must be attributed to the prolonged use of the liquor ferri sesquichloridi. Such a result might *à priori* be expected when the frequency of slight ulceration of the mucous membrane of the throat in typhoid fever is considered; and Fräntzel's experience of the drug has verified this opinion. Having had occasion to prescribe liquor ferri sesquichloridi in numerous cases of intestinal hemorrhage in typhoid fever, he observed among these a disproportionately large number of severe affections of the pharynx. As for the treatment of acute purulent mediastinitis—neither bleeding nor even tracheotomy can be expected to be of any use. Long and deep incisions, carried down to the trachea, would seem to Fräntzel to be the only rational measures to be adopted.—*London Medical Record*, July 1, 1874.

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*On the Diagnosis and Etiology of Unilateral Induration and Contraction of the Lung.*

Professor H. Nothnagel, in a clinical lecture on this subject (*Volkmann's Sammlung Klinischer Vorträge*, No. 66), mentions some interesting points in connection with physical diagnosis. He confines his remarks entirely to those cases in which the induration and contraction involve the whole of one lung, excluding all partial contractions. The most important elements in the diagnosis of this condition are stated to be derived from the inspection and palpation of the thorax. After describing at some length the well-known deformity of the thorax which is produced by the shrinking of the lung, and insisting upon the fact that there is complete absence of inspiratory expansion on the affected side, he alludes to the situation of the cardiac impulse. The heart is always displaced. When the left lung is affected, the impulse is usually higher and more to the left than natural, although in some cases there is no lateral displacement. When the disease is on the right side, the cardiac impulse is often imperceptible, the organ being covered by the enlarged left lung; if, however, the retraction be very considerable, the impulse may sometimes be discovered in the fourth right intercostal space, close to the sternum.

Another important sign of unilateral shrinking of the *left* lung is the existence of a distinct systolic impulse in the second left intercostal space, from four to eight centimètres (about 1½ inches to 3 inches) from the left border of the sternum. This is associated with a diastolic shock, which is perceptible to the hand in the same situation. These two signs, although by no means constantly met with, exist in a large number of cases, and when they are present, Nothnagel considers them as the most certain evidence of shrinking of the left lung. In explanation of their production, they are stated to be caused by the pulmonary artery; the systolic impulse due to the distension of this vessel during the systole, the diastolic shock to the forcible closure of the pulmonary

sigmoid valves. Similar phenomena may, however, occur in other diseases in which there is increased pressure in the pulmonary artery—*e. g.*, in mitral stenosis and insufficiency; but in such cases the pulsation is much nearer to the left border of the sternum, and not four to eight centimètres from it. In order that both the systolic impulse and diastolic shock should be produced in the situation named—(in the second left intercostal space, four to eight centimètres from the left border of the sternum) the following three conditions are necessary: 1. Displacement of the heart to the left; 2. Increased pressure in the pulmonary artery; 3. An induration of the lung covering the pulmonary artery, or so much retraction of this portion of the lung that the base of the heart is left free; and it is only in induration and contraction of the left lung that the concurrence of these three conditions obtains. In only one case of right-sided disease has Nothnagel observed any similar phenomena.

In speaking of percussion as a means of diagnosis, Nothnagel says that there are two signs which, when present, are certain evidence of contracted lung. These are the displacement of the diaphragm on the affected side upwards, and the dragging over of the mediastinum and the healthy lung towards the diseased side. The auscultatory phenomena and the character of the vocal fremitus present nothing diagnostic, as they vary according to the condition of the contracted lung.

Respecting the etiology of induration and contraction of the whole of one lung, Nothnagel says that much the most frequent cause is pleurisy. The pleurisy is the primary lesion, and it leads to a secondary change in the lung. This change consists mainly in a slow growth of connective tissue (a pulmonary cirrhosis), and it is this growth which leads to the fibroid induration and contraction of the organ. This pulmonary induration is only quite an occasional sequence of pleurisy. Why it should occur in some cases and not in others, it is difficult to explain. Nothnagel thinks that the greater the length of time which elapses before the absorption of the exudation commences to take place, the greater is the liability to this fibroid change. Although pleurisy is the most frequent cause of this condition, it may also result from morbid processes commencing in the lung; but even in such cases the pleura is often simultaneously affected. The morbid conditions of the lung, which may give rise to diffuse induration and contraction, are stated to be—abscess, gangrene, croupous pneumonia, and phthisis.—*London Med. Record*, April 15, 1874.

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### *On Rest in the Treatment of Chest-Affections.*

Dr. F. Roberts (*Practitioner*, June, 1874) recommends the following methods of treating various diseases of the chest.

Pleurodynia is to be treated by applying two or three strips of plaster firmly round the side over the seat of pain. The emplastrum roborans is a good form of plaster for these cases. In pneumothorax and pleurisy the strapping needs to be very firm and resisting, and therefore the best form is that of plaster covered over with two or three layers of strips of bandage, steeped in a mixture of gum and chalk. Should the pleural sac be much distended, however, the best plan of treatment would be to remove the air from the pleura by means of the aspirator, and then immediately to put on the apparatus. In acute pneumonia a complete state of general rest must be enforced. The physical examination of these cases should be made as seldom, and with as little disturbance to the patient, as possible. The patient should be instructed to limit the number of his respirations, to check his cough, and to speak as little as possible. Strapping does not appear to benefit these cases.

In acute bronchitis the object should be to disturb the patient and the respiratory organs within due limits, and to try and empty the bronchial tubes. Frequent examination is here to be commended; the patient should be directed to take full and deep inspirations from time to time, and coughing is to be encouraged. A half-sitting posture should be adopted, and prolonged sleep is to be forbidden at night as well as in the daytime. The act of coughing is often aided by applying a bandage tolerably firmly round the abdomen, including the lower margin of the thorax.

In cases of broncho-pneumonia, the treatment must be determined by the exact conditions of each case.—*London Med. Record*, July 1, 1874.

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*Communicability of Consumption from Husband to Wife.*

Dr. H. Weber read before the Royal Medical and Chirurgical Society (April 28, 1874) cases illustrative of this point. He had tested the question in his practice during more than twenty years, his attention having been first directed to it by some striking cases. He had the history of the results of twenty-nine marriages between women with more or less marked signs of consumption, who married healthy men, and of fifty-one marriages of tainted men who married healthy women. While only one of the husbands of the twenty-nine diseased wives became consumptive, eighteen of the fifty-one healthy women married to diseased husbands died from consumption. The eighteen women were the wives of nine husbands, one of whom lost four wives, one three, four two, and three one each. Dr. H. Weber gave an abstract of the histories of these nine husbands and eighteen wives, and then discussed the following points: 1. The communicability of consumption from husband to wife he did not regard as established, but as rendered probable; he could scarcely consider the results of his experience as merely accidental, although the risk of communication was probably not quite so great as it would appear from his cases. 2. The means of communication between husband and wife seemed to exist only rarely in the inhalation of the breath, though he did not regard this as impossible, but more frequently in the seminal fluid, either by direct absorption of the latter, or indirectly through the fœtus. 3. The suggestion made to him, that possibly the infecting husbands were tainted with syphilis, was not supported by the examination of the facts, either those relating to the husbands or those relating to the wives, including the *post-mortem* appearances. 4. The rapid course of the disease in the wives manifested more or less the character of galloping consumption, while the affections of the originally diseased husbands were in all cases chronic and quiescent, but well-marked, and leading in all cases but one to a fatal termination, though long after the deaths of the wives. —*Brit. Med. Journ.*, May 23, 1874.

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*On the Treatment of Phthisis by the Phosphate of Lime and the Juice of Raw Meat.*

Dr. Henry Blane, of Paris, in a short article in the *Lancet* (June 13, 1874), advocates this mode of treatment of phthisis:—

The treatment of phthisis by raw meat and alcohol was prominently brought to notice some years ago by Professor Fuster, of Montpelier. At first the results published were so favourable that it appeared that consumption had at last been conquered; but, unfortunately, the advantages gained by this treatment were not lasting—not that the raw meat was at fault, but merely because the patient could not be induced, after a certain time, to swallow the raw meat, or the stomach to tolerate it. The fault rests entirely with the mode of administration, and the principles on which the treatment was based still remain good, and by improving the form under which this valuable remedy can be administered we obtain from it all the advantages possible without any of its inconveniences.

Dr. Blane administered the raw meat in the following manner: A pound to a pound and a half of fresh beef, deprived of fat, bones, etc., is placed over a quick fire for a few minutes, in order to whiten and harden the external surface only; the piece of meat is then cut into two or three pieces corresponding to the size of the meat-press, and all the juice is extracted by the pressure of the powerful screw. The superficial coction is necessary to overcome the elasticity of the meat, which renders the extraction of the juice a very difficult matter unless more powerful machines be used than the simple one at present required. A pound and a half of good fresh meat gives a teacupful of juice. The juice should be prepared daily. This juice, having all the physical pro-

perties of raw meat, is easily digested, is well tolerated, and, served in the following manner, is always very grateful to the patient. The juice should be mixed with equal parts of tepid broth, made of bones and flavoured with salt and pepper, and to which tapioca, vermicelli, etc., can be added. Care, however, should be taken that the broth is never more than *tepid*, otherwise coagulation takes place, and the desired effect is not obtained.

The treatment of the consumptive patient by this method is the following: Early morning—Warm milk (not boiled), with bread and butter, and, if the appetite be good, some fat bacon and eggs. At eleven or twelve o'clock, breakfast, before which a drachm of the syrup of triple phosphate should be taken; during the meal itself, a dose of the muriatic phosphate of lime, and half the daily allowance of the raw meat juice in some broth; the meat should consist, according to appetite and digestive powers, of fish or poultry, or white meats, fresh vegetables, and a few glasses of good alcoholic wine. Dinner at six o'clock on the same principles: broth, with the remainder of the raw meat juice, and, instead of the triple phosphate, a dessertspoonful of cod-liver oil can be taken with advantage after the meal, if the liver be not enlarged and fatty, and the digestion good. The muriatic solution, or wine of phosphate of lime, should also be taken during the dinner. At night, before retiring to rest, a cupful of warm fresh milk, diluted one-third with Vichy water.

No medicines whatsoever, beyond those mentioned, should be administered, unless some special indications or some urgent symptoms claim their use. Anodynes, narcotics, cough mixtures, lozenges, blisters, inhalations, etc., are practically of no good, and but too often, by lessening the appetite or by irritating the patient, they increase the debility and hasten the fatal end. All hygienic rules—out-of-door exercise, ablution of the skin, etc.—should at the same time be carefully attended to. Under the influence of this treatment, Dr. Blane says, the appetite rapidly returns, the cough becomes less troublesome, the expectoration lessens, the night-sweats and all unfavourable symptoms decline and disappear, the patient gains flesh and strength, and the confirmed and helpless invalid, with proper care and prudence, can enjoy life once more.

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*On the Influence of Anæmia on the Nutrition of the Muscular Fibres of the Heart.*

The fatty degeneration of the internal membrane of the vessels, the degeneration of the muscular fibres of the heart, and the arrest of the development of the whole vascular system, are the three principal organic changes which have been recognized in chlorosis. Already partly pointed out in the collected edition of Virchow's works (*Gesämmtliche Abhandlungen*, p. 494), these facts are more fully developed in a special memoir on chlorosis by the same author. Since that time, many observers have also recognized the changes of the cardiac muscular fibres in a great number of forms of anæmia; for instance, in lying-in women who had died in consequence of profuse hemorrhage, and in persons who had died from marasmus after typhoid fever, or from affections of the digestive tube which had brought on serious troubles of absorption or nutrition.

Tschudnowsky, a Russian physiologist, has recently published a memoir, in which he has directly studied the influence of bleeding on the nutrition of the heart; and in which he entirely confirms the results obtained by clinical experience.

Dr. Perl, of Berlin (Virchow's *Archiv*, vol. lviii.), while taking note of these researches, wished likewise to assure himself of the effects of anæmia on the heart, and instituted a series of experiments on dogs, which were superintended by Virchow. He selected veins of a certain size, which were carefully isolated, then tied on the cardiac side. A thread was slipped under the vessel on the peripheral side, then the vein was opened; the desired quantity of blood was allowed to flow, and the operation was finished by tying the peripheric end. Arterial blood was not abstracted, except when the veins, having already been opened several times, had become the seat of thromboses, and consequently more or less impermeable.

Two different methods were adopted. In a first series of experiments, moderate but rather frequent blood-lettings were performed; that is to say, they were repeated every three or four days, but the quantity of blood never exceeded the hundredth part of the total weight of the animal. In a second series, the blood-lettings were few and far between, but copious. Every five or seven days a quantity of blood corresponding to three-hundredths of the entire weight of the animal was taken away.

In the dogs of the first series of experiments, the effects of the blood-letting were very slightly apparent, and recovery was rapid; the appetite was good, the reparation of the blood lost went on smoothly, though the number of bleedings spread over from thirty-six to sixty-nine days had amounted to from ten to seventeen. The animals were killed, and the necropsy revealed a perfectly normal condition of the muscular fibre of the heart; the striation remained perfect; there were no fatty elements except in the neighbourhood of the nuclei, which is an ordinary phenomenon with dogs.

On the other hand, the animals which had been submitted to unfrequent, though copious, blood-lettings (from five to eleven in an interval of from four to twelve weeks) were in a very different condition. They speedily fell into a state of marasmus, rapidly became emaciated, lost their appetite, and their lower extremities became œdematized; all, with one exception, succumbed spontaneously. One dog only did not present any anomalous appearances at the necropsy; in all the others the heart was flaccid, and of a pale and slightly yellowish tint. Fatty degeneration of the muscular fibres could be found in all parts of the organ; sometimes the striation was only interrupted by fatty corpuscles; sometimes it was no longer even perceptible, and only refracting granules, which resisted the action of acids and alkalies, were to be perceived. The degeneration was not universally distributed in the same degree; it was more decided in the papillary muscles of the left side of the heart, next in the corresponding fasciculi of the right side, next in order came the walls of the left side, and finally those of the right side. The process never showed itself in manifestations which were visible to the naked eye; and with the microscope, by the side of the degenerated fibres, others could be discerned which had remained intact. As the dogs were not suffering from any other disease, and as no clearly defined febrile movement could be discovered in them, from a clinical point of view, anæmia only could be designated as the cause of the lesions.

From a clinical point of view, these facts are of great importance, since they explain the more or less serious cardiac symptoms which show themselves in inveterate chlorosis. Chlorosis will be removed from the domain of purely humoral pathology to re-enter, up to a certain point, that of organic pathology.—*London Med. Record*, May 13, 1874.

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*Aneurism of the Abdominal Aorta successfully treated by the Administration of Gallic Acid and Subsulphate of Iron.*

Dr. S. Fleet Speir reports (*Med. and Surgical Reporter*, March 28, 1874) the following two cases:—

Case 1.—Alex. C——, aged 34, admitted to Brooklyn City Hospital Aug. 27, 1870.

On the 20th of May there was heard, for the first time, a murmur over the abdominal aorta; its maximum of intensity was just above and a little to the left of the umbilicus. A tumour was perceptible to the touch, firm, and limited pressure upon it was painful. The tumour pulsated, and its expansion was synchronous with the cardiac pulsation, and a distinct bruit could be heard over it. The diagnosis of abdominal aneurism was made, and was confirmed by consultation. The patient was at this time under the care of Dr. H. S. Smith, on the medical side of the hospital, and his treatment consisted of tonics and occasional cathartics. On the 6th of June he was transferred to the surgical wards, and came under my care. A consultation was held, and surgical interference was thought of for the relief of his distress. His debilitated con-

dition, however, induced me to abandon that idea, and I put him upon gallic acid, in half drachm doses, three times a day, before meals, and alternated with five minims of the solution of liq. ferri subsulphat. After this treatment there was a marked change in the character of the tumour. It became much more firm to the touch, and the impression was received of a solid tumour occupying the anterior surface of the aorta, and below it the passage of blood was but little interrupted. The tumour seemed to be near the cœliac axis. On the 11th of June he died suddenly, from the rupture of the sac of the aneurism. On post-mortem examination the aneurism was found as above described. A portion of its wall was very thin, and had given way near where it joined with the main trunk of the artery, and hemorrhage into the abdominal cavity caused his death. The whole interior of the sac of the aneurism was filled by firm layers of coagulated fibrine, which gave evidence of having been recently deposited. The fact that this fibrine had been deposited so immediately after the use of the gallic acid and iron, and the readiness with which the effused blood coagulated, induced me to believe that these remedies had been, in part, at least, the cause of the rapid coagulation of fibrine within the sac, and I determined to give it another trial on the first opportunity.

Case 2.—Chas. A——, aged 36, born in Denmark, a sailor by occupation, weight 202½ pounds, entered the Brooklyn City Hospital May 13, 1871. In January of the same year he had been treated for lumbago, with relief; he returns with same complaint. In 1865 he had gonorrhœa, but has had no other venereal complaint; his habits have been good; is not a hard drinker. In February the pains for which he had been treated in January returned, in the small of the back. The pain increased in severity, notwithstanding local and constitutional treatment. In the latter part of May the pain in the back was so great that he was unable to leave his bed. About the 1st of June a pulsating tumour was discovered, for the first time, just to the left of the umbilicus. This had all the symptoms of aneurism of the abdominal aorta, and was accompanied by diminution of the current of blood in the left femoral artery. By the 1st of July the patient was helpless, and lost about forty pounds, and got relief from the intense pain only after hypodermic injections of morphia. He was now put upon liq. ferri subsulphatis, iv minims, three times a day, alternated with gallic acid, ʒss, and was kept in bed. In August he was greatly improved; the tumour was smaller and more firm, and gave less pain. In the latter part of August his improvement was very marked; he could walk about the wards; the morphia was discontinued, and he began to regain his lost flesh. At this time he weighed 195 pounds, and was able to do light work without fatigue. The tumour was small, very firm, and gave no pain on pressure. No difference in the current of blood in the femoral arteries could now be detected. Oct. 10th he was "discharged cured."

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### *Tumours of the Spleen in Primary Syphilis.*

Dr. A. Weil, of Heidelberg, in a short article on this subject in the *Centralblatt für die Medicinischen Wissenschaften*, March 7, remarks that the syphilitic affections of the spleen are numerous. Besides gummata and amyloid degeneration, Virchow described an indurated and a soft hyperplastic tumour, the latter depending chiefly on a multiplication of cell-elements, and indicating a slighter degree of irritation. Some of these diseases may be diagnosed during life with more or less accuracy. Gee, Eisenchitz, and others, have attached especial importance to the presence of splenic tumour as an indication of hereditary syphilis. Dr. Weil says that, contrary to all previous statements, so far as he has been able to find any allusion to the subject, he has ascertained, by palpation and percussion, the presence of enlargement of the spleen during the stage of primary syphilitic induration in three cases under his notice in the hospital at Heidelberg. Two of the patients came into hospital soon after infection, three or four weeks before the first appearance of a syphilitic exanthem; the third had already had a macular eruption for a month before admission. The splenic tumour was well marked in all the patients at the time of their ad-

mission. The breadth of the splenic dulness in the axilla was from 4 to 4¾ inches; in front the dulness extended to the ribs, where in one case the spleen could be distinctly felt. Under antisyphilitic treatment, the splenic enlargement completely disappeared within periods varying from five to ten weeks. As there was no other apparent cause for the splenic tumour, Dr. Weil attributes it to syphilis. He has not found it in cases of blennorrhœa, or of local contagious ulcer; and it is absent in many cases of constitutional syphilis. He believes that the best explanation of the origin of these splenic tumours is, that they arise from syphilitic infection of the blood, and are analogous in this respect to the splenic enlargements arising from the circulation of irritant matters in the blood in typhus and intermittent fevers and in the acute exanthemata. According to this theory, the anatomical substratum of the tumour will be hyperæmia and multiplication of the cell-elements of the splenic pulp; this, however, remains to be proved by pathological examination.—*Brit. Med. Journ.*, April 25, 1874.

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*Relation of Renal Apoplexy with Cerebral Hemorrhage.*

Dr. Auguste Ollivier remarks (*Archives Gén. de Med.*, Fev. 1874) that the influence of chronic affection of the kidney on the production of cerebral hemorrhage is well known, but in the present essay he proposes to consider the converse fact, namely, the influence of cerebral hemorrhage on the production of certain renal lesions. He proceeds to give a series of cases that have fallen under his observation, amongst which are the following: 1. A man, aged 74, was attacked with apoplexy, with right hemiplegia of the limbs and face. In twenty minutes after the attack the urine was found to have become albuminous; death took place on the fourth day. On post-mortem examination effusion of blood was found to have occurred under the meninges, and a clot had formed in the left optic thalamus and corpus striatum, which had burst into the corresponding ventricle, and had made its way into the middle ventricle and the opposite lateral ventricle. The cerebral peduncles, cerebellum, pons, and medulla oblongata were healthy. Both kindeys, but especially the right, were found to be congested. 2. An attack of apoplexy in a man aged 68, with hemiplegia of motion and sensation on the right side; ten minutes after, coma. The urine was normal up to the time of the appearance of the coma, but then began to contain albumen. Death occurred in the course of nine hours. The autopsy showed a large hemorrhage into the white substance of the left cerebral hemisphere, which had burst into the ventricles, and even entered the upper part of the aquæduct of Sylvius; both kidneys were congested, the right highly so, and with an ecchymotic spot upon it. M. Ollivier reports several other similar cases. He then proceeds to give the details of numerous experiments he has recently performed on rabbits, showing, in accordance with the statements of Bernard, Brown-Séquard, and others, that puncture of the floor of the fourth ventricle is almost constantly followed by the appearance of albumen in the urine. The cause of this is not, however, quite clear; some, with Schiff, considering it to be due to paralysis of the vaso-motor nerves; others, with Brown-Séquard, to be due to spasm of the veins, or of both arteries and veins, causing engorgement and rupture of the capillaries.

M. Ollivier, in conclusion, points out that albuminuria of cerebral origin is of more frequent occurrence than is generally admitted, but that our present knowledge does not enable us, from the existence of albuminuria in cases of cerebral hemorrhages, to localize exactly the seat of lesion. At the same time, where the symptoms of lesion of the medulla oblongata are deficient in an apoplectic patient, it may be said that the presence of albumen in the urine indicates either a hemorrhage situated at the base of the brain, or an extensive hemorrhage elsewhere exerting compression on the base. In all instances it must be regarded as a very serious symptom.—*Practitioner*, April, 1874.

### *Remarks on Eighty Cases of Tapeworm.*

Dr. T. Spencer Cobbold, Lecturer on Parasitic Diseases at the Middlesex Hospital Medical College, contributes (*Lancet*, June 6, 1874) some remarks based on an analysis of eighty cases of tapeworm.

Amongst the remedies employed, he says, I find male fern to have been the favourite. My notes on this point are not at all complete; yet I ascertained that this popular drug had certainly been administered in 28 instances, turpentine in 13 instances, and kousso in 11 cases; the other less commonly employed remedial agents being pumpkin-seeds, kamala, tar-water, calomel, aloes, sulphate of copper, santonine, etc. In particular and individual cases four or five of these agents had been employed in succession. As regards my own treatment of these self-same cases I find that in the mere matter of drugs I have resorted to male fern in 52 cases, and in 39 of these it was the only remedy employed. In the 13 remaining cases either areca-nut, kamala, or kousso was resorted to, frequently in combination with the male fern in the simple form of powder. Only in such cases as those in which other parasites were either known or suspected to be present have I enjoined the use of santonine and certain other drugs which I deem utterly unsuitable as tæniafuges.

In regard to the special results obtained by myself in connection with these 80 really very miscellaneous "cases of tapeworm," I have, in the first place, to dismiss the 24 delusive ones, and to them I must also add 9 others in which either a simple opinion or merely preliminary advice was offered. This leaves 48 cases only in which I had any chance of testing the action of appropriate tapeworm remedies. In exactly 24 out of the 48 I ascertained that the cure was complete, and, except in some six or eight of the remaining patients who refused to persevere in the treatment, I believe that the same good result followed. Only in a comparatively small proportion of the cases have I been enabled to make the necessary, complete, and final stool inspections, by the results of which alone one is enabled to pronounce a cure or otherwise on the dismissal or departure of the patient. However, I now usually insist upon this essential detail of management being properly carried out. Thus, in 17 out of the 24 cures above mentioned, the head of the worm was actually obtained, and in the 7 other cases it was ascertained that the parasite never returned after treatment. The management of genuine cases of tapeworm is incomplete without attempts on the part of the practitioner to secure the head by personal investigation of the matters discharged. It is not well to leave this task to others. On four separate occasions I have known the patient to remove the head of the worm with the rest of the parasite from the stools, but, with one exception, these persons were unaware of the character and importance of their individual finds. Guided by my own more recent experiences, I think we ought always to reckon upon curing straight off 9 out of every 10 cases that are presented to us for treatment—provided, of course, we have the proper facilities offered to us. However, it is only in a proportion of cases that the necessary examinations can be efficiently made. Thus, last year, I enjoyed this opportunity of searching for the head of the worm in six cases only, but in every one of these cases I removed the head of the tapeworm from the matters discharged. In every case the head was found detached from the body of the worm, and in one or two instances it was completely isolated from the neck.

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### *Successful Treatment of Pityriasis Rubra.*

Dr. Tilbury Fox, in an article in the *Lancet*, Feb. 28, 1874, states that pityriasis rubra (general dermatitis) is said by many dermatologists to be incurable. If treated upon correct principles, he finds it to be very amenable to remedies in many cases. The following is a case in point:—

W. B.———, aged fifty-two, came to University College Hospital on the 28th September, 1872, stating that he had been under a club doctor for two months with his disease, and was rapidly getting worse. He said that he had always enjoyed good health, save that he had had the gout on and off, badly,

for fourteen years. He admitted "taking a little," by which it appears he meant five or six glasses of ale or gin and water a day. Has passed "stones" per urethram, the size of the smallest pea. His urine is habitually red, thick, and scanty.

The skin affection began two months ago—namely, in July, 1872—by little red scaly spots on the arms and legs. Other spots then appeared quickly over the body. These speedily enlarged, and invaded the whole of the body within ten days or so. The body was, in fact, reddened, and threw off scales and large flakes. The head was red and scurfy. The face and the palms of the hands were apparently the only parts not affected.

There can be no doubt that the disease was typical pityriasis rubra, though it was termed by the doctor psoriasis. The urine became scanty at the same time.

Sept. 28th. When I first saw the patient he had the general aspect of a man with pityriasis rubra. The whole skin was very hyperæmic, but there was no thickening of the derma, as is observed always in well-marked and certainly general psoriasis. The blood could be squeezed out of the skin, which had a dry, yellowish look, and felt harsh; but the surface was covered over with lamellar scales, exactly as one sees in pityriasis rubra; they were not heaped up, not smallish, imbricated, and of silvery aspect as in psoriasis; they were freely shed—as much as two handfuls in quantity, during the night, for instance. But there was more than this. The legs were enormously swollen and tense; they were markedly œdematous, and this, together with the extreme pallor or semi-sallow aspect and puffiness of the face, pain in the back, and scanty supply of urine, gave one the idea that the man was the subject of Bright's disease; but on examining the urine, it was found to be tolerably healthy.

*Remarks.*—This case was clearly one of pityriasis rubra—viz., hyperæmia of the skin and exfoliation of the cuticle. It began like, and ran the usual course of, pityriasis rubra, involving the whole surface from head to foot in a very short time, except that the disease got well before the lapse of a very long time. And it is especially in regard to the success of the therapeutics adopted that I wish to call attention. In the first place, I have to observe that the conditions were favourable to successful treatment—though the disease is said by some to be incurable, because the case came under observation at an early date, before the hyperæmic state of skin had existed any length of time, so as to have given rise to secondary alteration, such as infiltration into the textures, and the like.

The case seemed to me to be exactly one in which the free use of diuretics was called for. It is an established rule in renal therapeutics to stimulate the skin to increased action in cases where the kidneys are congested, or in other conditions in which it is desirable that they should be given rest from work. In the case of a hyperæmic state of skin, where this hyperæmia is not removable by local remedies, and where it is extensive, it is likewise desirable to stimulate the kidneys to increased activity, to relieve the skin of its work—to give it rest. In the case under notice the man was actually making much less than an average amount of urine; hence conjoined to his hyperæmic skin was a general puffiness or semi-œdema of his skin, especially his legs, as before stated. The patient began to take a diuretic mixture, composed of spirit of juniper, one drachm; acetate of potash, half a drachm; bicarbonate of potash, half a drachm; and infusion of calumba, one ounce, for each dose, three times a day. He continued thus, rubbing in simply oil to his skin, from Sept. 28th to Nov. 30th, 1872, taking also four vapour baths towards the end of this interval, as the skin began to recover its normal state. His kidneys acted well, the swellings of his legs subsided, and his skin gradually became less red and scaly On Dec. 7th he began to take tincture of the perchloride of iron in fifteen minim doses three times a day, and on Jan. 25th, 1873, was pronounced well.

This is now the fifth case of cure of pityriasis rubra which I have had under this plan of getting the kidneys to do extra work so as to relieve the skin, and give it rest, whilst it is soothed by oily inunction, this being followed up by the exhibition internally of perchloride of iron, which acts as an astringent to the weakened cutaneous vessels.

*On a Method of treating Tenia Tonsurans.*

Dr. Edgar A. Browne, writing to *The Practitioner* of May, recommends the following method of treatment as requiring no attention on the part of a nurse or parent, and needing only to be renewed at intervals of three or four days. A margin of healthy hair is to be cut quite short or shaved round the patch. A brisk rubbing with the oleum picis rectificati, or some similar hydrocarbon, is the next stage, and the reddened and saturated patch is to be thickly dusted with a powder composed of tannin, iodine, and gum arabic. This is to be moistened with a few drops of the oil, and gently but firmly pressed into the skin with the end of a small cork. The process is to be repeated till the whole patch is covered with a layer of paste about an inch thick, which is allowed to dry. The firm hard scab thus formed may be left undisturbed for three or four days, when it should be moistened and scraped off, and a fresh application made.—*London Med. Record*, July 1, 1874.

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## Surgery.

*The Action of Modern Bullets on the Animal Body.*

Dr. Ernst Kuester, of the Augusta Hospital, has published in the last number of the *Berliner Klinische Wochenschrift* an interesting paper on this subject. In a paper read last year before the German Surgical Congress, Professor W. Busch, of Bonn, called attention to the fact that the Chassepot bullet, when shot from a short distance into the human body, made a simple aperture of entrance, but that its aperture of exit was larger than a fist, and that there was very extensive fissuring and crushing of the bones. The same phenomenon had been described by Huy and Sarrazin in 1867; but they did not attempt to explain it. Dr. Busch supposed that the ball became melted and broken up by forcible contact with a hard substance, and acted like a mass of shot on the parts lying behind. Dr. Küster, at the time when Dr. Busch's paper was read, had made a similar observation as to the effect of the bullets, but could not adopt Dr. Busch's explanation. He has since made a number of experiments, which, with the courteous sanction of the ministry of war, who placed at his disposal arms, ammunition, and men, and with the assistance of Major Schenck, were carried out at the Royal Military School in Spandau.

In making the experiments, a large target was placed behind the animals, so as to enable the condition of the bullets to be observed after their passage through the body. The distances were 5, 20, 100, and 800 paces. The arms used were a sporting rifle (muzzle-loader with pointed bullet) the needle-gun, Chassepot, Mauser, and Henry-Martini rifles; the animals used for experiments were horses and wethers. The latter were first killed by a volley from all the weapons; then shots were discharged at the dead body, and after eight days a further series of experiments was made on the carcass, which was at that time undergoing decomposition. The following were the general results of the investigation:—

1. There is no essential difference in the action of bullets on the living and on the dead body. With reference to this subject, Dr. Küster calls attention to the fact, that in consequence of the greater toughness and resistance of the skin of animals, the aperture of exit is not so large as in the human body. In one case, the skin was so tough, that the point only of the ball penetrated the skin of the back, and its force was then diminished. On dilating the opening and introducing the finger into the wound, there was found to be just as extensive destruction of the soft parts and bones, as in the human body. It was only in those parts where the skin was thinner and lay close to the bone, as in

various parts of the head of the bone, that it was sometimes torn to a greater extent, but never so much as in man. The extent of injury of bones, however, was not less than in the human subject.

2. The extent of the destruction is in inverse ratio to the distance, and in direct relation with the initial velocity of the bullet. At 800 paces, although the characteristic peculiarities of the wounds were still present, they were greatly reduced in intensity. The smallest wounds were produced by the sporting rifle (*Fagdbüchse*); the bullets, although put out of shape, remained entire in the body, even when discharged at short distances. Then followed the needle-gun, the Chassepot, and the Mauser rifle, which produced frightful destruction of the bones and soft parts.

3. The destruction of the tissues is produced by the lead becoming heated by collision against a solid substance, and consequently broken up, but without being melted. The bullet is mechanically divided: it leaves the finest particles of lead in the recesses of the wound, while the fragments of various sizes pass out along with pieces of shattered bone. On this point, Dr. Küster differs from Professor Busch, who supposes a melting of the lead to take place. Busch's view appears to derive confirmation from the fact, that when a lead-bullet is discharged against an iron target, the lead is spread out in the form of a star; and this, it is argued, shows that it becomes melted. But Schädel, of Heidelberg, hung a small bag of powder before the target; the bag was repeatedly torn by the splinters of the bullet, but without producing an explosion, which must have taken place if the lead had been melted. There must also be a great difference, according to whether the bullet, travelling with full force, is completely arrested, or meets with an obstacle which it can overcome.

At the meeting of German naturalists in Wiesbaden, Professor Busch related some experiments to show that lead loses its cohesion in proportion as it is heated. If two bullets, one cold and the other heated, be allowed to fall on a stone from a height of six feet, no impression will be made on the first, while the second will be distinctly flattened. That a heating of the ball does take place, is an evident result of the physical law, that whenever it meets with resistance a part of the force is changed into heat; and further, when a bullet remains sticking to the target, it is always warm. Again, when a bullet is discharged from a short distance into a heap of moist sand, the edges and the further end of the channel made by the ball are always warm. By these facts, the manner in which the injury is produced in the animal body is easily explained. The bullet shatters the first bony lamellæ with which it comes into contact, becomes heated, and is consequently broken into several fragments against the projecting portions and angles of the bone. In correspondence with this destruction of the bullet, the wounds made from short distances by the Chassepot and Mauser, which have the greatest initial velocity, were frightful. Most of the bullets passed through the animals' bodies reduced by one-half or more, and greatly altered, and made on the target an irregular impression surrounded by a crown of small pieces of lead. Along with these were found fragments of bone, muscle, hair, etc. Dr. Küster does not remember having once seen a simple bullet-opening in the target.

The next point was, to observe whether hardened balls have the same effect. This was *à priori* not improbable, as Pirogoff had noticed the remarkably extensive splintering produced by the copper bullets of the Tscherkesses. Dr. Küster, however, found that—

4 The injuries described are produced only by bullets of soft lead, not by those made of hard lead. Bullets of hard lead are used with one only of the modern weapons—the English Henry-Martini rifle. The hardness is produced by amalgamation of the lead with tin in the proportion of 12 to 1. The initial velocity of this rifle is nearly as great as that of the Mauser, and yet the wound produced by it is very much smaller. While with the latter the aperture of entrance into the bone was irregular and often very extensively splintered, and while the amount of crushing increased in extent in the track of the ball, the Henry-Martini bullet always made a simple and more or less circular opening. If the edge of a rib were hit, the loss of bone formed the segment of a circle corresponding to the circumference of the ball. The aperture of exit was also

generally roundish, though larger; there was either no splintering, or it was limited to the immediate circumference of the aperture. The hole in the target was without exception simple; and the ball, when found in the target, was not at all, or only slightly, misshapen. Dr. Küster has never found splinters of lead in the track of the wounds made by these bullets. In one case only did he find a bullet of this kind much misshapen; it had been discharged at a distance of 100 paces, and remained sticking in a bone.

Dr. Küster states, as a fact of importance, that at a distance of a hundred paces the Henry-Martini bullets, with one exception, passed through the greatest diameter of the body of a horse, while the Mauser bullets frequently remained in it. This is explained by the greater resistance which the latter have to overcome in consequence of the greater amount of misshapement which they undergo; it also shows that the passage of a ball right through the body generally indicates much less danger than when it remains in it.

These results, Dr. Küster says, are capable of practical application in several directions. In the first place, they are a gain to forensic medicine. The statement made in text-books, that gunshot wounds are more extensive in the living body than in the dead, and that this affords a means of distinguishing whether the injury has been inflicted during life or after death, can no longer be tenable. No distinction exists in this respect, at least with the arms with which the experiments were made. On the other hand, a careful examination of the wound, especially when it passes through bone, may very well show whether the ball was of soft or of hard lead, and allow some estimate to be made as to whether it came from a distance or was discharged near the part. A still greater gain, however, is to be derived from the investigations by military surgery. The opinions previously entertained as to the action of shot have been shaken by the introduction of the modern weapons, and require reform. In future, in judging of the severity of an injury, it will be important to ascertain at what distance and from what weapon the shot was discharged, and whether it was of hard or of soft lead. The penetration of the bones of an extremity by a Chassepot or a Mauser bullet at short distances will in nearly all cases demand immediate amputation.

Dr. Küster next refers to the bearings of the question on the interests of humanity. The use of explosive bullets of small calibre is forbidden by international agreement; but, if it be shown that bullets of soft lead, at least at short distances, act just like explosive bullets, and that a close combat with such bullets can be nothing but a horrible butchery, the members of the Geneva Convention must use every effort to obtain an international verdict against soft lead bullets.

In some of the actions in the late war, when the combatants fought at short distances, the surgeons were struck with the frequency and severity of the injuries of bones, and the size of the apertures of exit. At that time, the reason of this was not understood, and it was supposed that explosive bullets were used. The researches of Dr. Busch and Dr. Küster have explained the matter; and Dr. Küster says that he owes it to a brave opponent, to state with satisfaction that the French stand thoroughly acquitted of the charge of having committed an act of unworthy and interdicted barbarity.—*Brit. Med. Journ.*, May 9, 1874.

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### *On the Advantage of opening the Capsule before making the Corneal Section in the Operation for Senile Cataract.*

One step of the operation for extraction of senile cataract—the theoretically simple process of opening the capsule—Mr. Spencer Watson finds (*Medical Times and Gaz.*, May 9, 1874), presents some difficulty and not a little danger. However fully dilated the pupil may have been before making the corneal section, no sooner is this step completed than the aqueous, if it has not already escaped, rushes out, and the pupil contracts, the iris coming of necessity in contact with the cornea. Supposing the operation to be Graefe's, the next step is to excise a piece of iris, and then comes the laceration of the capsule.

The removal of a piece of iris facilitates this step, but at the same time makes it more dangerous. It opens the space for the admission of the cystitome, and allows it to have a wide range of action without coming in contact with the iris; but it also much increases the risk of dislocating the lens and causing prolapse of the vitreous. If the capsule happen to be tough, and the suspensory ligament weak and friable, this accident is very likely to happen; and especially if the fixing forceps is being used, and the patient is under an anæsthetic. If, however, the operation is the old flap or any other operation not necessitating the removal of a piece of iris, the difficulty of lacerating the capsule freely without bringing the cystitome into contact with the iris is almost insurmountable. But this is not the only danger. The point of the cystitome must, in order to make a free opening of the capsule, pass behind the iris, and it is then of course out of sight, so that its movements can only be guessed at by observing the length and motion of the uncovered portion. Hence injurious friction of the uveal surface may be set up, or, on the other hand, an insufficient opening may be made in the capsule, either of which errors may lead to subsequent disasters. The use of Wecker's cystitome forceps only renders the danger still greater.

Contrasted with these methods let us consider the plan of opening the capsule by means of a curved cataract-needle, introduced through the cornea before the corneal section has been made. This operation was advocated by M. Correnti, of Florence, in 1872. He thinks the chief advantage is in the infiltration of the aqueous humour between the capsule and the lens, and that this facilitates the subsequent escape of the cataract; and he was very well satisfied with the result in several operations by Graefe's plan, in which he had tried this preliminary laceration of the capsule (see *Annales d'Oculistique* for September–October, 1872).

Having operated in this way in seven cases with satisfactory results, Mr. W. has come to the conclusion that it offers the following advantages in practice:—

1. The pupil, if previously dilated by atropia, remains dilated, and the iris, therefore, is out of the way of the needle.

2. The pupillary area is clearly seen, and the movements of the needle, therefore, can be guided into the precise positions required.

3. The nature of the cataract is more clearly ascertained than can be done by means of focal illumination or ophthalmoscopic observation. The density and thickness of the cortex, and its amount relative to the bulk of the nucleus, can be more satisfactorily made out.

4. There is no danger of dislocating the lens or of rupturing the suspensory ligament and so leading to almost certain loss of vitreous.

5. The information derived from the appearance of the cataract, and especially of its cortex, after lacerating the capsule, enables the operator to modify the subsequent steps in accordance with the varying bulk or density of the cataract or its capsule. If, for example, it is found that the nucleus is very large and dense, a large corneal section will have to be made, and an iridectomy also if there is any difficulty about the escape of the lens with moderate pressure. If, on the other hand, the cataract is composed of a bulky cortex with a very small nucleus, a small corneal incision will suffice.

If the capsule be tough and thickened by inflammatory exudation, it may be desirable to extract the cataract within its capsule, and this can be done by modifications of the ordinary methods. With a cataract of the Morgagnian variety, having a fluid milky cortex and small nucleus, it will be better to extract it in its capsule; and this condition could be easily ascertained by the introduction of the needle before making the corneal section. It is not so easy to make the diagnosis of a Morgagnian cataract by the ordinary methods.

The method of operating is as follows: If the patient be not under the influence of an anæsthetic it will be possible, by fixing the eye in the manner employed in ordinary discission operations, to dispense with the use of the speculum and fixing forceps during the first step. It is an advantage to do without the fixing forceps if possible, as there is then less likelihood of an escape of aqueous humour on withdrawing the needle. There is nevertheless an advantage attending the use of the fixing forceps—viz., that the needle can

be used with more freedom and precision. The pupil should have been previously fully dilated by atropia. The needle used should be slightly curved near the point, and should be the finest possible in the shank. It is entered very obliquely at the lower and outer quadrant about 1‴ from the corneal margin. Its point is then pressed against the centre of the capsule, and a puncture made with a view to ascertain the consistency and nature of the cortex. This done, the operator decides whether to remove the cataract in its capsule or not. If he decides to lacerate the capsule, the point of the needle is carried round the upper and inner margin of the lens with a semicircular sweep, and then across the lower and inner margin with a second sweep, two semicircles being joined above and below by separate movements of the needle if necessary. It is then withdrawn slowly and carefully; and if its passage through the corneal layers has been sufficiently oblique, there will be no loss of aqueous humour, and the pupil will remain dilated as before. If, however, aqueous has unavoidably been lost, the operation had better be completed on the following day, or even a week later. The subsequent steps of the operation will depend upon the information obtained in the first step. Any of the numerous modifications of Graefe's operation, or the old flap operation, or the Warlomont or Liebreich operation, may be employed according to the supposed suitability of the particular method to the case. Having, however, satisfied ourselves that the capsule is freely lacerated, it will generally be found that a much smaller corneal section will be necessary than if this has not been previously done; for the separation of the capsule from the cortex, and of this again in some measure from the nucleus, will have been favoured by the admission of the aqueous, and hence a much less amount of pressure will be required, and a smaller opening will be needed for its extraction. The only possible objection that is likely to be urged against this operation is that it may occasionally cause an escape of the aqueous humour, and so delay the completion of the operation; but this is an objection that will not have much weight. It is not likely to happen often, and when it does is of no consequence. In order to avoid it, it is necessary to have a very fine needle and to enter it very obliquely through the corneal layers. Perhaps some may object that the capsule cannot be so freely lacerated in this way, from the limitation of the movements of the needle; but this is a matter of experience, and it is practically not a serious obstacle to the success of the operation. It is essential, however, that the needle should be introduced on the temporal side of the cornea, either in the upper or lower quadrant; and hence the operator, if standing behind his patient, must use the left hand for the left eye, and *vice versâ*. If not ambidextrous, he had better, on operating upon the left eye, stand facing his patient and use his right, but this is hardly so convenient a position for the subsequent steps of the operation, and does not allow of so good a rest for the hand in this step as if the operator were behind. Each operator will find out for himself the most convenient and easy attitude, but for the ambidextrous there can be no doubt that the position behind the recumbent patient offers many advantages throughout the operation, and especially in the laceration of the capsule.

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### *Observations on Hare-lip.*

Sir William Fergusson is of opinion that the intermaxillary portion or portions involved in hare-lip is or are very frequently the cause of much annoyance to the surgeon, often, indeed, being almost the direct cause of failure in operations, and he records (*Brit. Med. Journ.*, March 28, 1874) his experience on this subject.

In the case of double hare-lip, with double cleft in the alveolar ridge, there may be great projection, or little or none. In the latter case, particularly if the columna and lateral portions of the lip be of good size, there may be no need for meddling with the intermaxillary mass. If, however, the projection be considerable, or what may be called great, and if the columna and side portions of lip be scanty, there ought then, in my opinion, to be no hesitation about taking away the projection at its junction with the vomer. The attempt to

push this part back by gradual pressure is troublesome, or well-nigh impossible, in most instances, even if, as has been proposed, its narrow neck be broken. In either instance, it has never been told from experience in what condition, in what direction, the teeth come in the part thus displaced. In either or both instances, I have no doubt in my own mind that the teeth, if they came at all, would so slope backwards as to be of no value either for show or for use. There is, however, indubitable proof that, without thus meddling with the part, there are only two incisors of respectable size, after all, and these are of such indifferent quality, that they had better have been dispensed with at the earliest date. I, therefore, never hesitate to remove the intermaxillary mass when it seems the least in the way of a satisfactory operation. The advantages of doing so seem to me greatly to preponderate, and, if there be cleft hard palate at the same time, there is far greater chance, in after years, of the gap becoming narrower, whilst, in adult life, there will be greater facility for the assistance of the dentist. But, I imagine, there is less hesitation or difficulty in the surgeon's mind in the case of capacious double gap, than when there is only a single one with considerable projection of the intermaxillary margin. It is to such cases that the chief object of these observations is directed. If it be difficult to apply compression on the intermaxillary portion in double cleft, it is still more so when only one side projects; for its base is broader and firmer. The instances where there is no special projection are common, and require no comment, as there is then, as regards this matter, no obstacle to a satisfactory and successful operation; but, when there is a projection, if considerable, it is a more serious obstacle to these results than those inexperienced may imagine. I believe that this condition is a frequent cause of failure in the ordinary operation, particularly if it be done without the truss-compressor on each cheek to push the lateral portions of the lip towards the mesial line. In such a case, the surgeon is naturally anxious to leave the alveolar ridge untouched, and, in accordance with a common practice, when it is desirable to secure union by first intention, when the stitches or needles are withdrawn, strips of plaster are carried from cheek to cheek to hold the union firm. Scarcely a greater mistake can be made, for the line of union in the lip being generally, under such circumstances, exactly over, or opposite to, the sharp angle of the projection of bone, the young cicatrix is pressed against it, and gradually thins away, until it is fairly split open, when the operation proves a failure. This, I have a strong impression, is an explanation of the failure of many cases that do not seem, in any special way, complicated. I do not mean that straps always conduce to this effect, and that, therefore, they should never be used. On the contrary, I have very frequently seen them of much service. But, if the single projection alluded to be conspicuous—in which case, there will always be a somewhat sharp, angular margin—it is, in my opinion, best to get rid of it at the time of the operation. In my own practice, I was at one time in the habit of cutting the projection away with sharp small bone-forceps, dividing gum and bone at the same time, and aiming chiefly at getting rid of the projection. This usually involved all the intermaxillary bone on that side, and implied, perhaps, little heed of what damage might be inflicted on the sound side, although, latterly, I always passed the blades into the mesial line between the intermaxillary bones, so as to secure this side from material injury. In the course of my experience, I fancy that I refined on this practice. I found that it was well to detach the portion as high up towards the nostril as could conveniently be reached, and here I discovered that, in all young subjects, there was only cartilage to be divided. This could easily be done with the knife or scissors, and so, for many years, I have used only one or other of these instruments. Usually, I have passed the scalpel through the mucous membrane, under the frænum, up between the bones, and divided the cartilage, periosteum, and gum, to sever the part; and thus the use of cutting bone-forceps has been dispensed with, for, to say the least, such an instrument is coarse-like and clumsy in an operation for hare-lip on an infant only a few weeks old.

Whilst I can offer little objection to this proceeding, I fancy that I have recently fallen on one equally efficacious and void of certain objections which, I think, might be urged against it. Instead of this sweeping wholesale abstrac-

tion, I content myself with making an incision, vertical, sloping, or horizontal, with a scalpel through the mucous membrane and periosteum, over the projecting piece of bone; with a few touches of the knife, or a little squeeze with finger and thumb, I so separate these tissues as to permit the entrance of a gouge of a quarter or three-eighths of an inch in breadth, with which I scoop out the body of the milk incisor-tooth in as far as it is formed, taking no heed of the cyst or of that of the permanent one, and even cut out such wall of bone as may be there; usually, at four or eight weeks, only small plates of bone. In this way, the hard projection is removed, and the tissues that remain offer no obstruction to the union of the junction of the lip in front, whilst the operation, as it appears to me, is less destructive, therefore more conservative, in character. There is thus left only the mucous membrane, with possibly some periosteum, which form a soft cushion behind the wound in the lip, and so the remaining intermaxillary bone is not divested of covering so thoroughly as when cutting instruments are passed in the mesial line to take all away on the offending side.

I have now adopted this plan in several cases, and have been much pleased with the effect and result. In one instance, I used a silk stitch to hold the edges of the wound in the mucous membrane together, but I doubt if it be needful, and I have not seen any spurt of blood from the deep part of the wound, such as that which I have often found, in other instances, has required the application of a pointed heated cautery. The wound has healed without attracting special notice. In the case where the stitch was used, the thread came away spontaneously, and, in the end, the gum appeared as if there had been no projection, and, therefore, no such operation.

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### *Operation for Cleft Palate.*

In the No. of this Journal for July we noticed an operation proposed and performed by Sir William Fergusson for the closure of cleft in the hard palate, after the failure of the ordinary operation of Langenbeck, or in cases where this operation is unsuitable. Although this modification has hitherto been remarkably successful, considering the severity of some of the cases in which it has been employed, it had one drawback. The two bony fragments were liable to become tilted. To obviate this, Sir. William (*Lancet*, June 20, 1874) has modified his operation. After paring the edges of the mucous membrane, he pierced the hard palate with an ordinary shoemaker's awl in two places on each side of the cleft, close to the margin, in such a manner that the holes on one side of the fissure were directly opposite those on the other side. A separate silk suture was then passed through each hole on one side, carried into the nasal cavity, and brought into the mouth again through the holes on the opposite side of the cleft. When the sutures were thus secured, the hard palate was divided on each side, outside the apertures, by means of a chisel in the manner previously described. The silk sutures were then drawn together, and the two fragments of bone brought into gentle apposition. Sir William remarked that since first performing this operation he had found that it had been previously recommended by Dieffenbach.

Though this last modification lengthens somewhat the operation, and increases perhaps the difficulties of its performance, it nevertheless greatly enhances its value. In due course we shall furnish our readers with the results of the cases treated by this means.

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### *Tolerance of the Heart to Wounds.*

Numerous examples are on record of lesions of the heart in various grades, punctures, contusions, etc., without resulting notable accident, without, indeed, any sign which would directly reveal their existence, without any appreciable trouble in the functions of this organ. We have called attention to such cases from time to time in our pages. Our former regretted collaborator Jamain has collected almost all the known casés of this kind in his *thèse de concours*

on wounds of the heart in 1857. Among the cases since recorded, we might recall as of especial interest that reported in the service of M. Piorry at the Charité in 1858. It was the remarkable case of prolonged sojourn of a needle implanted in the intraventricular cavity; the case by Prof. Brugnoli (Bologne) 1863, of wound involving both ventricles, terminating in recovery; the case by M. Tillaux, 1868, of sojourn for a year of an iron wire in the left ventricle; and, finally, the quite recent case of two punctures of the heart, without accident, in paracentesis of the pericardium, reported by M. Bouchut in one of his clinics, Dec. 1873.

Now we have a new case of violent contusion of the heart without the least apparent accident.

An old soldier was received during the early part of March in the Hôtel-Dieu, service of M. Richet, a few moments after an attempt at suicide. He had discharged a revolver upon the region of the heart. The ball entered below the left nipple, and did not escape, but made a track behind by the side of the vertebral column, where it seemed to be lodged. The wound occasioned very little inconvenience, and almost no dyspnœa. So little was his distress that the internes believed that the ball had not penetrated, but had simply traversed the circumference of the thoracic cavity. A careful examination with the *esprit* of M. Richet led to a contrary conviction. He recognized, in fine, by percussion, practised with great caution, dulness at the presumed level of the projectile. The summit of the left lung yielded a tympanitic resonance, and the ear applied to the chest perceived coarse mucous râles with the metallic bruit. Finally, there supervened some expectoration of pure blood, which could leave no doubt of the affection of the lung. The lung had been thus traversed, and there was left, most probably, hemato-pneumothorax.

As to the heart, it beat with its ordinary regularity. Nevertheless, M. Richet believed that he must maintain reserve as to a possible lesion of this organ, the orifice of entry of the ball being at the level of the apex.

M. Richet prescribed blood-letting copiously, *coup sur coup*, iced drinks, and internal hemostatics.

On the next morning the patient was seized with an attack of cough, which was followed by a sharp hemorrhage from the wound. With every movement of inspiration and expiration there escaped a considerable quantity of frothy blood, with the bubbling discharge of air. At the same time there developed emphysema of all the upper parts of the body. The heart remained always regular, as if impassive, as also the pulse. Death followed in the afternoon from the continued hemorrhage, which nothing could arrest.

At the autopsy was recognized a fracture of the rib at the level of the entrance of the ball. The path of the ball traversed the pleura and the pericardium successively, at the level of the apex of the heart, which was the seat of a small contused wound. About a tablespoonful of clotted blood lay in the pericardium. About the wound could be seen the traces of an extensive contusion of the surface of the heart, produced, without doubt, by friction against the fragments of the rib. The left inferior lobe of the lung was traversed in its whole extent.—*Clinic*, May 2, from *Gaz. des Hôpitaux*, April 4, 1874.

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### *Congenital Curvature of the Penis, with Hypospadias and Adhesion to the Scrotum.*

Dr. R. F. Wier reports (*New York Med. Journ.*, March, 1874) two cases, successfully operated upon, in which there existed a triple malformation, hypospadias, curvature of the penis, and adhesion to the scrotum. The rarity of the two latter conditions, which are generally, if not always, associated with hypospadias, may be judged from the fact that Guyon, in his excellent work on the "Malformations of the Male Urethra,"[1] has collected but four cases: one, on the authority of J. L. Petit, where curvature and adhesion were conjoined, and in which the penis was separated by operation from the scrotum, but the

[1] "Vices de Conformation de l'Urèthre chez l'Homme," 1863.

curvature remained; two others (Buisson,[1] and Dupont[2]), where adhesion only existed, and in which liberation was easily effected by division of the frænum-like band; and the fourth (Buisson[3]) where curvature only existed, and which is quoted by Guyon to show the superiority of the method used in that and in the present cases over that suggested by Petit, who advised making a series of minute incisions in the contracted urethral band.

Buisson, however, remarks that he has seen several similar cases, but gives no particulars. In Petit's own works,[4] however, besides the case alluded to above, where he did not operate himself, believing the case to be irremediable, is mentioned the *post-mortem* examination of a youth of ten or eleven years of age, afflicted with curvature of the penis and scrotal adhesions, whose case had been pronounced by him some time previously as being beyond the reach of surgical skill.

The excellent result obtained by Petit, as well as that obtained in the two following cases, disproves partially the doctrine of Roubaud,[5] who speaks of the incurability of this malformation, and calls the impotency with which it is associated absolute.

Case I. Isaac B., aged twenty-one years, was admitted into St. Luke's Hospital January 4, 1871 (service of Dr. Weir), with the following congenital malformation of the penis, the other genito-urinary organs being normal: The penis was strongly curved downward, so that the glans presented at the base of the scrotum, and was apparently held there by the integument of the scrotum being continued over the dorsum of the penis, a *raphé* on each side marking the junction of the parts, and forming at the glans the free superior portion of the prepuce. The glans was uncovered and the urethra hypospadic, and opening about half an inch from the site of the meatus, from which place it could be traced into the perineum as a short, tense band acting as the cord to the arc formed by the penis. This was demonstrated to be the urethra, and of normal diameter, by the passage of a No. 14 English sound. The patient passed urine between the thighs, although, by raising the partially movable glans, he was enabled to throw the jet forward, and thus avoid wetting himself. He contemplated marriage, and therefore asked for surgical relief. It was explained to him that, in the event of liberating the penis, the opening of the urethra would necessarily be carried further back, and even might seriously interfere with procreation. Desiring the operation performed, he was on the 9th of January etherized, and an incision made on each side of the scrotum sufficiently far from the body of the penis to afford skin enough to cover the under surface when released, and the flaps dissected up to the penis. This constituted the first step of the operation; the second consisted in separating the urethra, with the corpus spongiosum, from the corpora cavernosa as far back as the posterior margin of the scrotum. This required but few cuts of the scissors, as the band was only about one and a half inch long, and produced no effect upon the curvature of the penis. On stretching out the curved organ, the septum between the corpora cavernosa could be easily felt as a tense, thickened band, and its division constituted the third step in the operation. It was accomplished by a tenotomy-knife, introduced, however, not so far as described by Buisson, and cutting freely the septum in its lower part and about half-way between the glans and scrotum. Immediately after this section was made, the curve was readily abolished and the deformity thoroughly overcome. The transverse incision made involved, however, the tissues of both corpora cavernosa, and gave rise to troublesome and persistent oozing of blood, only arrested by a ligature placed around an acupressure-needle. The skin-flaps were then united by a suture on the under surface of the penis, and the gaping edges of the scrotal wound brought together without tension; having, however, first carefully secured the mucous membrane of the urethra by fine sutures to the

[1] Buisson, "Traitement de l'Hypospadias," p. 536.
[2] Dupont, "Moniteur des Hôpitaux," February 4, 1853.
[3] Buisson, *op. cit.*
[4] "Œuvres complètes," edition 1837, p. 715.
[5] "Traité d'Impuissance et de la Stérilité," 1855, p. 167.

integument at the posterior angle of the wound, that is to say, at the junction of the scrotum with the perineum. The penis was laid against the abdomen, without need of a retaining bandage, and cold-water dressings were applied to the parts.

The result of the case was exceedingly satisfactory, though at the situation of the needle there was tardy reparative action, not only from the presence of the ligature applied, but also from the frequent erections that ensued, enjoyed by the patient in spite of the pain therefrom.

The second case was similar to the preceding.

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*Sarcoma Testis, with Remarkable Complication.*

Mr. Tyrrell communicated to the Surgical Society of Ireland (*Irish Hosp. Gaz.*, Feb. 1874) a case of sarcoma of the left testicle, which he had removed from a farmer, aged 40. The testicle had been retained in the inguinal canal, during the patient's boyhood, without any inconvenience to him. On his reaching manhood it descended into the scrotum, but until the last few years, when it began to increase in size, he could return it himself into the abdomen. He married six years ago, and has four children. On proceeding to remove the testicle (sarcoma of it having been diagnosed), it was found on opening the tunica vaginalis, that there was a portion of omentum in its sac, and attached to the testicle. This most unexpected and unusual complication was treated by ligaturing the omentum with a carbolized gut thread, and having cut through the part below the ligature, the stump of omentum and ligature was returned into the abdomen. The spermatic cord was tied *en masse*, and the diseased gland then removed. The patient recovered rapidly. On microscopical examination, the tumour was found to be a well-marked example of a spindle cell sarcoma. The complication in this case was one of extreme rarity, if not altogether unique. Mr. Tyrrell has not been able to find a similar case recorded It was instructive as showing how cautious one should be, as Mr. Tyrrell observed, in applying an écraseur to the cord before the testicle is laid bare—a method of procedure which has been recommended by some surgeons.

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*On the Palliative Treatment of Cancer of the Rectum by Linear Rectotomy.*

M. Verneuil, in a lecture given at the La Pitié Hospital, and reported in the *Gazette Hebdomadaire*, March 27, 1874, has demonstrated the advantages which may be derived from linear rectotomy in cancer of the rectum. Besides the three cases he published in a memoir, read at the Société de Chirurgie in 1872, he has since performed this operation in two other cases, with the effect of removing the pain and giving great relief. Up to that time rectotomy had been performed with the linear écraseur in the posterior median line, and as high as possible. In the fourth case, which formed the subject of M. Verneuil's lecture, he resected a small band about two centimètres wide, along the posterior wall of the rectum. To facilitate this operation, M. Verneuil cut a triangular piece of skin, of which the base corresponded to the point of the coccyx and the apex to the posterior commissure of the anus; this strip largely opens the postrectal cellular cavity, and allows the operator perfect freedom of working on the exposed rectum.—*London Med. Record*, June 17, 1874.

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*On Ligature of the Deep Femoral Artery.*

Professor Azzio Caselli recommends (*Bullettino delle Science Mediche*, December, 1873) ligature of the deep femoral artery in cases where this vessel, or one of its branches, is wounded, and also where it supplies a large tumour of the thigh with blood. The operation, which was suggested to him by the failures that have attended ligature of the common femoral, is performed in the following manner:—

An incision, through the skin only, 2¾ inches long in thin, and 3 or 4 inches

long in fat subjects, is made from the crural arch outside the line of incision for ligature of the common femoral artery. The panniculus adiposis is carefully cut through, and the internal saphenous vein is isolated and turned inwards. The aponeurosis of the fascia lata is divided on a director, and the crural artery and nerve are exposed by tearing the cellular tissue; the vessel and nerve—the loose cellular tissue between them being torn through with a director—are held apart, and the deep femoral artery is exposed and tied.

Dr. Caselli performed this operation in a case of large tumour occupying the two upper thirds of the inner and posterior part of the thigh, before removing the tumour. The ligature was applied about four-fifths of an inch from the common femoral artery, just above the origin of the external circumflex. The operation was performed with ease, and there was not much hemorrhage. The patient died, however, of ichorrhæmia at the end of fifty-five hours.—*London Med. Record*, April 22, 1874.

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*On the Radical Cure of Varix by the Injection of Hydrate of Chloral.*

Professor Luigi Porta, in an article communicated to the Royal Lombardian Institute, and quoted in the *Gazzetta delle Cliniche* (No. 1, 1874), gives an account of the clinical observations which he has made on the coagulant property of hydrate of chloral, and especially of its use in the treatment of varix.

He reports fifteen cases of varix of the leg treated successfully by the subcutaneous injection of hydrate of chloral, beginning with a gramme, and then reducing the dose to a half or a third of a gramme. The coagula are formed at once, and the patient is confined for a few days to bed, to obviate the risk of phlebitis. The coagula ultimately are absorbed, and the veins become atrophied, or remain pervious, though not varicose.

The accidents which may occur are the following: The thrombus may soften; but this only impedes the cure for a time. Phlebitis may occur; but it is slight, and disappears in a few days. Very limited suppuration may take place; it does not delay the cure, and perhaps depends on the escape of a small quantity of the chloral into the connective tissue. This may be prevented by drawing up the piston before withdrawing the needle. Circumscribed sloughing of small portions of the skin has been observed in old subjects, probably also from escape of the chloral into the connective tissue. Professor Porta thinks it probable that this mode of treatment will be found applicable also to varicocele (of which he has had a successful case) of various subcutaneous nævi, aneurismal varix, and hæmorrhoids.

Dr. Valerani, writing on this subject in the *Annali Universali di Medicina* for December, 1873 (*Gazzetta delle Cliniche*, No. 5, 1874), says that any new method tried for the cure of varix should be free from danger either immediate or remote, easy of application, and fairly constant in result. All these conditions are present in the treatment proposed by Porta.

In order to explain the *modus operandi* of this treatment, Dr. Valerani makes some observations on the venous circulation in the lower limbs. Until within the last few years, he says, it has been believed that the subcutaneous venous system of the lower limb is complementary to the deep venous circulation of the limb; that is to say, that the saphenous veins are destined to receive the refluent blood from the deep veins when the circulation in these is obstructed by muscular contration or by other causes. The error of this opinion, however, has been demonstrated beyond doubt by Verneuil, Le Dentu, and more recently by Giacomini. On examining the large anastomoses between the superficial and deep veins, it is always found that the valves have their concavity directed inwards; that is, they are so dispersed as to allow the blood to flow from the superficial to the deep veins, but not in the opposite direction. The reflux from the deep to the superficial veins is only possible when the valves are imperfect.

Varix of the subcutaneous veins is then a consequence of dilatation of the deep veins. The deduction from this is, that a fibrinous coagulum should be formed at the point where a valve exists in the normal state, so as to take its place, and prevent the reflux of blood from the deep to the superficial veins.

Professor Porta, not having taken into consideration the anastomoses between the saphenous and deep veins, does not say what points should be selected for making the injection of chloral. On the other hand, Dr. Valerani says that the points where the varicosity is hardest and most prominent, are those where the injection should be made; they indicate the neighbourhood of the opening of an anastomosing branch, where there should be a valve, which is, however, more or less insufficient.

The operation is very simple. The injection is made with a Pravaz's syringe, the point of the needle being inserted in the largest knots of the varicose zigzag. The patient should be standing, that the veins may be more tense; if he be in bed, they are rendered tense by the finger. There is no hemorrhage.

Valerani has seen the injection followed by softening of the clot, slight phlebitis, abscess, and sloughing; but, in spite of these complications, the result may be said to be always successful. The complications are always local, and are not attended by constitutional disturbance. It is sometimes necessary to repeat the injection, especially when the clot softens, and the vein opens and gives exit to some drops of black blood, threads of softened fibrin, and even drops of sanguinolent pus. After a longer or shorter time, the varix disappears, and the veins resume their normal dimensions, presenting the aspect of small cords, not tortuous or painful.

Dr. Valerani gives the history of several cases of large varix which he has treated with excellent result by this plan.—*London Med. Record*, March 4, 1874.

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### *Amputation by the Galvanic Cautery.*

Within the last two years Dr. Paul Bruns has performed twelve amputations of the limbs by the galvanic cautery; viz., eight amputations of the thigh, two of the leg, one of the forearm, and one of a finger. The use of the galvano-caustic knife did not prevent hemorrhage during the operation, while the galvanic wire, when carefully applied, did so. To prevent hemorrhage, the principal artery of the limb should be compressed, and the back flow of venous blood restrained by a circular ligature. Esmarch's method might be applied with advantage. The galvanic wire is most applicable in amputation by the circular method. The skin, having been cut through, is drawn back; the wire is then applied higher up, and the muscles and periosteum are divided; after which, the bone is sawn through. In the forearm and leg, the wire is passed by the aid of a needle through the interosseous space, and the muscles are divided in two portions. Towards the end of the operation, the current must be somewhat weakened, as the wire is apt to become red hot and cut through the tissues too rapidly. The large arteries must be tied after the operation. The eschar is very thin, but it affords security against secondary hemorrhage. The shock, pain, and traumatic fever, were very slight in all the cases. The progress presented nothing remarkable; the danger of pyæmia did not appear to be less than after operation by other methods; and the healing process was slow. Bruns considers that the merit of the operation lies in the greater security against hemorrhage and the small amount of constitutional disturbance.—*British Med. Journal*, April 11, 1874, from *Archiv für Klin. Chir.*, vol. xvi.

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### *Primary Amputation of Upper Extremity, including Scapula and outer half of Clavicle; Entrance of Air into Subclavian Vein; Recovery.*

John Clark, aged 14, a factory operative, was admitted into the General Infirmary, Leeds, under the care of Mr. Jessop, April 28, 1873. On the day of admission, whilst passing underneath some machinery by a route which he had been accustomed to take, his left arm was caught between large cogwheels, the teeth of which were about two inches long, and dragged, he thinks, quite through. He did not lose consciousness immediately, but was able to walk a few yards towards some fellow-workmen, when he fainted. After a temporary rally, he again became insensible, and in that condition was brought to the Infirmary. He had lost some blood, but not a large quantity.

On admission, he was extremely pale and very restless, tossing his head from side to side. The pulse was hurried and scarcely perceptible; the breathing irregular; the pupils dilated, and the eyelids closed. He was covered with cold sweat, and lay insensible, except when roused to temporary consciousness by loud shouting. The left humerus was found to be broken across between the anatomical and surgical necks; and the fractured ends, which were fully exposed, were very rough and jagged. The soft tissues connecting the limb with the trunk were all divided, except about three fingers' breadth of skin on the outer and posterior aspect of the shoulder. The subclavian artery, securely plugged, was seen faintly pulsating beneath the clavicle.

The operation was performed during the continuance of the shock. Ether having been administered on a sponge, the small bond of union between the arm and the trunk was divided by means of a small catlin. The tissues in front of the shoulder joint, though severely bruised, were carefully dissected up so as to make an anterior flap. The joint was then opened, and the head of the bone removed. The subclavian artery in the third part of its course was made secure by careful torsion. It was now discovered that there was a considerable deficiency of cover; hence it was decided to remove the scapula, which was at once proceeded with by reflecting the skin and dividing its upper attachments. The body of the bone was then grasped by the left hand, so as to put the muscles attached to the base on the stretch, which were divided from before backwards. Whilst cutting through the last attachments of the scapula, two distinct and loud whiffs were heard, caused by the rush of air into the subclavian vein. Digital pressure was immediately applied to the open vessel; but the patient became suddenly deadly pale and pulseless. The administration of ether was at once stopped; and, without waiting for a rally—whilst assistants were busy with artificial respiration, drawing the tongue forward, and dashing cold water on the face and chest—the operation was proceeded with, the remaining connections of the scapula being divided, and the outer half of the clavicle being removed by bone-forceps.

Only about three ounces of blood were lost; and only three arteries, including the subclavian, required twisting. The wound was well sponged out, and the edges were brought as near as possible by wire sutures; nevertheless a small space was left uncovered, from a deficiency of integument. A pad of lint was firmly strapped over the wound, and over that a flannel bandage was applied. Twice during the operation, his condition was most critical. As soon as he became conscious, brandy and water was administered. He was wrapped in blankets, and allowed to remain on the operation-table for several hours, occasionally taking a little brandy and water; thence he was removed to the ward, and, after lying for a few minutes before the fire, was placed on a water-bed.

For the first few days after the operation, he was feverish and delirious; but after that the temperature gradually decreased, his pulse became slower and stronger, and his general condition improved in all ways. The edges of the flaps and a considerable part of the anterior one sloughed; the sloughs separating on May 6th, leaving a healthy granulating surface, which on May 7th had about a dozen grafts of cuticle implanted, after which it healed rapidly.

He was allowed to get up for the first time on May 8th, ten days after the operation, and felt no inconvenience from so doing. The wound had perfectly healed on the 17th; and he was made an out-patient on June 21st.

August 18th. As he was walking in the streets, his foot tripped against a stone, and he fell heavily on his left side, hurting himself severely. He came to the Infirmary soon afterwards, when swelling and ecchymosis were found over the situation of the recent wound. He was put to bed, and had evaporating lotion applied to the injured part; but he became feverish and poorly, and on August 20th (two days after he fell), an abscess about the size of a hen's egg was opened over the cut end of the clavicle, giving exit to a quantity of fetid sanious pus, with some bubbles of air. This was followed by a slight attack of erysipelas, the redness extending for a few inches round the wound and in streaks down the back, from which he recovered in a few days. The

discharge gradually diminished in quantity, and the wound healed, so that he was discharged cured on August 27th.

October 20th. He came to report himself at the Infirmary, looking well nourished and strong. He said he had no pain, and was as well as before the accident.—*Brit. Med. Journ.*, Jan. 3, 1874.

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*Fracture of the Index Finger from Muscular Action.*

Mr. Edward Bellamy, Senior Assistant-Surgeon, Charing Cross Hospital, records (*Brit. Med. Journ.*, March 28, 1874) a singular accident which occurred in the out-patient practice of Charing Cross Hospital March 16th, namely, fracture of the proximal extremity of the index finger of the left hand, as a result, presumably, of muscular action. A man, 55 years of age, in making a back-handed blow at his retreating son, as far as Mr. B. can understand, just missed striking him, thereby expending the extreme radial extension of his wrist without meeting with the expected amount of resistance. He immediately experienced great pain and loss of power over the hand, and, on his coming for advice, it was evident what had occurred; the fragment, which was freely movable beneath the skin, was drawn upwards by the extensor carpi radialis major, and powerfully abducted by the lower fibres of the first dorsal interosseous muscle; and, when these muscles were put in action, the deformity was singularly apparent. The line of fracture being considerably beyond the reflection of the synovial membrane, it is not probable that further complication will follow. When one takes into consideration the mode of development of the bone, the accident appears the more remarkable. The treatment was sufficiently obvious.

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*On Rupture of the Tendon of the Triceps Cruralis.*

M. Gosselin describes (*Lond. Med. Record*, March 25, 1874) a patient, aged 62, suffering from slight locomotor ataxy, having above the left patella a great gap. On putting the fingers into this gap, the superior border of the patella could be hooked up, and the posterior surface of the bone felt. The patient stated that it was due to a fall four months before, and was followed by considerable swelling. He fell backwards, and pulled a piece of furniture on to the part injured. Treatment was inefficacious. M. Gosselin draws attention to two important and instructive points, viz: 1. The non-consolidation; 2. The treatment to follow in similar cases. 1. Consolidation in these cases is a rare event. M. Demarquay thoroughly treated this question in 1863, and has collected twenty-two cases. This accident is not extremely rare, and the scattered observations have been collected and published in the *Gazette Médicale* by M. Demarquay. Among these he found that there were some who rapidly became cured—after twenty or thirty days—and others were not benefited. In proceeding to inquire into the cause of this non-union, M. Gosselin admits that the explanation is not easy, seeing that tendons unite usually in other situations. Nélaton, in his *Éléments de Pathologie Chirurgicale*, insinuates that the want of success is due to inappropriate treatment, *i. e.* that the limb has not been rendered sufficiently immovable, and he attaches great importance to the dextrine bandage. M. Gosselin does not agree with this view, but believes that there are other conditions, such as idiosyncrasies, superadded to the treatment, which cause this unsatisfactory state of things. In the present case, M. Gosselin thinks that there was rupture of the synovial membrane of the joint as well—a rare condition, and one which he has seen a very few times.

2. In ordinary cases the success of the treatment depends much on the position of the limb, its immobility, and the application of a proper bandage. The limb should be placed on an inclined plane, the foot much raised, and, so that the immobility may be quite complete, a posterior splint must be applied, then, over all, an immovable bandage.

*Use of Hot Water in Surgery.*

Prof. Frank Hastings Hamilton reported in the early part of last year ten cases of surgical operations treated by submersion in warm or hot water, with allusion to a number of minor cases, all of which were remarkably successful. He now reports (*Med. Record*, May 15, 1874) six other cases with the comment that, "no treatment hitherto adopted, under our observation, has been attended with equally favourable results.

"Under this plan the area of acute inflammation is exceedingly limited; erysipelatous inflammation has been almost uniformly arrested or restrained, when it has actually commenced, and it has never originated after submersion; gangrene has in no instance extended beyond the parts originally injured, and when progressing it has in most cases been speedily arrested (in gangrene hot water, or water at a temperature of from 100° to 110° Fahrenheit, is to be preferred). Septicæmia and pyæmia have not ensued in any case in which submersion has been practised from the first day of the accident. Purulent infiltrations and consecutive abscesses have been infrequent, and always limited to the neighbourhood of the parts injured, and of small extent. Traumatic fever, usually present after grave accidents, when other plans of treatment have been pursued, as early as the third or fourth day, has seldom been present when this plan has been adopted, and in no case has the fever been intense or alarming."

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## Midwifery and Gynæcology.

*Molar Pregnancy and Uterine Hydatids.*

Dr. T. M. Madden exhibited to the Dublin Obstetrical Society specimens of both of the above conditions. The first case was that of a woman, aged 25, the mother of two children, the youngest of whom was three years of age. When Dr. Madden first saw her, she supposed herself to be in the fifth month of her third pregnancy. She had been attacked with pains and hemorrhage, and the os was of about the size of a florin. After a dash of hemorrhage the os further relaxed, and the uterus expelled a large mass of hydatids; these grew from a pedicle. The hemorrhage ceased after their expulsion. In the second case, a woman, æt. 40, mother of seven children, believed she was pregnant thirteen months. She thought she had felt quickening at the usual time, but when she considered herself to be six months gone, the motions of the child ceased, and the abdomen became flat. After due examination, Dr. Madden introduced the sound. The next day he was sent for. The patient had hemorrhage, and soon after his arrival, the uterus expelled a complete cast of its interior, at least one-third of an inch in thickness. The patient had been quite regular since. Dr. Madden referred to the various views which were held as to the nature of these bodies; whether they were the product of conception or not, or an abnormal growth. He, Dr. Madden, believed that they might occur in women of undoubted chastity, and that in many cases they were caused by ovarian disease.

Dr. Evory Kennedy said that he knew of no case in which hydatids were not the result of impregnation. The hydatid was a different form of disease from the mole; the latter appeared to be more of an intra-uterine polypoid growth, which it was sometimes necessary to detach from the uterus.

Dr. M'Clintock said that the term uterine hydatids was a double mistake, and a double misnomer: as these growths were not hydatids, and were not a disease of the uterus but of the ovum. The Medico-ethical question, as to how far the expulsion of hydatids is to be taken as an indication that pregnancy has taken place, was a most important one. He, Dr. M'Clintock, had never seen hydatids

occur except as a result of impregnation, and doubted whether there was any clear case on record of their having taken place in a virgin. An important fact connected with these so-called hydatids was, that the mass might be retained beyond the ordinary period of utero-gestation; as was shown by one of Dr. Madden's cases.

Dr. Madden, in reply, referred, among others, to Dr. Ashwell's cases of uterine hydatids occurring in females in prisons, in which pregnancy could not well be supposed to have taken place.—*Irish Hosp. Gaz.*, March 2, 1874.

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### *On Lymphangitis in Puerperal Pathology.*

Dr. Tilt read a very exhaustive paper on this subject, before the Obstetrical Society of London (*Lancet*, June 13, 1874). His conclusions were condensed in the following propositions: 1. Pelvic cellulitis, benign or septic, originates in the lymph spaces, and in the capillary lymphatics that have been wounded in some lesion of the utero-vaginal mucous membrane. 2. Wherever situated in the pelvis, cellulitis follows the same course, but varies in name and in symptomatology according to its topographical disposition, and to the organs and the tissues that circumscribe it. 3. From the patch of capillary lymphangitis implicated in a mucous membrane lesion (inflammation) may spread to one or more of the nearest lymphatics, and may be benign or septic. 4. One lymphatic may pass on inflammation to another, so that a continuous chain of purulent lymphatics may extend from the septogenetic lesion to the lumbar lymphatic glands, and such acutely inflamed lymphatics often inflame their surrounding cellular tissue, their glands, and proximate organs. 5. When lymphatic glands do not succeed in barring the progress of inflammation, they also inflame their surrounding cellular tissue, and may thus cause an internal bubo wherever there be a pelvic lymphatic gland. 6. Occasionally peri-uterine inflammation has no other origin than this frequent origin of abscesses of the broad ligament. 7. Purulent lymphatics on their way to the lumbar glands may inflame the subserous cellular tissue in the iliac region, and thus cause iliac abscess. 8. The subserous lymphatics and the peritoneum are so intimately united by physical contact and physiological action, that it is almost impossible for subserous lymphangitis not to cause peritonitis. 9. The subperitoneal lymphatics being continuous with and contiguous to those of the ovary and the oviduct, they may be inflamed by subserous lymphangitis, particularly when it is septic. 10. The contamination of the blood by lymphatic pus leads to the inflammation of those parts that are in physiological connection with the lymphatic system, such as the serous and synovial membranes, and the spleen, whilst phlebitis more frequently causes metastatic abscesses, if it be not their sole cause. 11. Though often overlooked in *post-mortem* investigations, sporadic puerperal lymphangitis is not uncommon, but is more frequently met with in connection with, and eclipsed by phlebitis. 12. The worst cases of lymphangitis (puerperal) have their modified counterpart, and their presentment subdued, in non-puerperal pelvic pathology, and more frequently than is admitted lymphangitis is the cause of speedy death from uterine operations. 13. Whether women be poisoned by puerperal lymphangitis or puerperal phlebitis, the general symptoms are the same in nature and in intensity, and the local symptoms vary according to the amount and to the variety of its primary and of its secondary lesions. 14. The increase in size and in number of pelvic lymphatics during pregnancy, and their increased functional activity, strongly support the rule not to operate on pregnant women. 15. As the liability to puerperal lymphangitis is in direct proportion to the number and to the gravity of lesions inflicted on the utero-vaginal mucous membrane by tedious labours, it is advisable to shorten, by the use of the forceps, according to modern practice. 16. The bathing of a puerperal wound in an ichorous discharge is so dangerous that disinfecting vaginal injection should be made so soon as the lochial discharge becomes in the least offensive. 17. The innocuity of injecting a solution of tincture of iodine into the womb immediately after delivery, and of a solution of perchloride of iron very soon afterwards, warrants the injunction to inject

into the womb some strong disinfecting substance whenever the lochial discharge is fetid. 18. The frightful mortality that has attended some epidemics of puerperal lymphangitis justifies the horror of large maternities entertained by the profession.

Dr. Palfrey did not altogether agree with the author as regards the frequency of this disorder. It was, without doubt, more common in maternity hospitals than generally believed, and yet, though he was attached to one, he had never seen a case, and in the London Hospital they had never lost one. No proper comparison could be made between the London and Paris hospitals, the ventilation and hygienic arrangements in the latter contrasting unfavourably with the former. He would ask whether the author advised injecting iodine into the uterus three or four hours after labour, and whether there was no fear of the fluid passing through the Fallopian tubes into the peritoneum. He had seen one case where it was fatal. In another, Dr. Head injected the perchloride of iron into the non-pregnant uterus; death occurred shortly after, and iron was detected (post mortem) in the peritoneal cavity. He thought it was not prudent at any time to inject fluids like tincture of iodine and the perchloride of iron into the uterus. The results were often most disastrous. He would ask whether the author considered pelvic cellulitis and lymphangitis to be one and the same condition. He had never seen glandular enlargement in the pelvis in pelvic cellulitis, and it was not, as a rule, a fatal disorder. Remembering that what the author taught would go forth to the world, he desired to express his dissent to the views enunciated respecting the harmlessness of intra-uterine injections. If it was so difficult for fluid to travel along the Fallopian tubes, how was it that semen often traversed them, and we got extra-uterine pregnancy as the consequence? He considered it was very easy for fluid to pass.

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*On a Case of Rupture of the Vagina with Protrusion of the Bowels.*

Dr. F. Fehling (*Archiv für Gynäkologie*, vol. v. part i. 1873) reports a case at the Gynæcological Clinik in Leipzig, occurring in a woman sixty-three years old, mother of thirteen children. Her last pregnancy was a miscarriage. The youngest child was twenty-three years old. All the labours were natural and easy with two exceptions, which happened together. In both instances the forceps were used. The last was thirty years ago; since then she had always had a falling of the womb. Every kind of pessary had been tried, but with no avail. For the last thirteen years, she had ceased to do anything for it. It invariably came down on standing, sitting, or walking, forming a tumour about the size of a child's head. When she lay down, it went up without any assistance. Whenever it caused her any inconvenience, she was in the habit of reducing it with her fingers. Whilst she was ascending the steps of the village well with a weight on her back the womb prolapsed. She hastily endeavoured to replace it with her fingers, using considerable force. She felt something give way, and immediately the bowels protruded.

Dr. Fehling was summoned eight hours after the accident, and found the woman in a state of collapse, with the small intestines protruding from the vulva, forming a mass as large as a man's head. The intestines were cool to the touch, showed no signs of peristaltic movement, and were of a purple colour. Putting the woman slightly under the influence of chloroform, he tried to replace the bowels, which he succeeded in doing, but could not retain them in position, from want, as it seemed to him, of sufficient room for so large a mass in the abdominal cavity. A second effort was made, the patient being placed on her knees and elbows, and completely anæsthetized, but with no better result. The woman rapidly sank, and died eleven hours after the accident, of shock. The *post-mortem* examination showed a great increase of omental fat and a thinning of the vaginal walls.

The author states that he believes this to be an unique case, as he finds no report of any instance of ruptured vagina under such circumstances; it shows how easily the vaginal walls may be torn in a case of prolapsus uteri of long duration. In all such cases, care should be used in reducing the prolapse. He

also thinks the inability to keep the intestines in position when replaced, arose from the capacity of the abdomen being diminished through the long-standing prolapsus uteri.—*London Medical Record*, April 1, 1874.

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*Treatment of Uterine Disease.*

Dr. Thomas Addis Emmet, in some remarks before the Medical Library and Journal Association of New York (*New York Med. Journ.*, July, 1874), laid stress upon the fact that throughout the menstrual life of the female, the organs of generation exercise a dominant influence over the nervous system; in health, through the reflex system, they act as the fly-wheel to the mechanism. Therefore, he said, so soon as any serious local difficulty of a chronic character is established, the nervous force becomes lowered, general functional derangement supervenes, and impaired nutrition follows as a sequence. Although we are unable to cure the local difficulty until we have improved the general condition, yet we can set the ball in motion by lessening the local source of irritation. Unless we can control the pelvic circulation, and at least impart a temporary tone to these vessels, it will be found in the end that little has been accomplished. We have our remedies for local application within the uterine canal, and much can be accomplished by mechanical means when appropriate. But in the simple remedy, hot-water vaginal injections, we possess the most valuable means of relief when properly administered. Although it has now been many years since this remedy was first introduced into practice, but a small portion of the profession appreciate its use or understand its action. It is generally conceived that the application of heat by this method relaxes the vessels and increases the congestion. This it does at first, but, if prolonged, the capillaries are excited to increased action; as they contract, the tonic stimulus extends to the coats of the larger vessels, their calibre becomes lessened, and, with an approach to healthy action, the congestion diminishes. No one applies a hot poultice with the view of increasing the congestion of the parts, but, as any old woman would explain it, "to draw the inflammation out," that is, to lessen the congestion by causing contraction of the vessels. That such is the effect of the continued use of a poultice is shown by the bleached and wrinkled appearance of the tissues after its removal. We can cause capillary contraction also by the use of cold, and the effect is even more prompt, but, when reaction comes on, the tissues will become more congested than before. In brief, the immediate effect of cold is contraction, and with reaction we always have dilatation; heat, on the contrary, causes dilatation at first, and its action is followed by contraction afterward.

If a woman be placed on her back, with the hips elevated by a properly-shaped bed-pan under her, and a gallon or more of hot water at 98° or of a higher temperature be slowly injected into the vagina by means of a Davidson's syringe, the mucous membrane will become blanched in appearance, and the canal as diminished in size as if a strong astringent had been administered. While the hips are elevated, the vagina will retain, during the injection, a large quantity of water, which by its weight will distend every portion of the canal, so that it will come in direct contact with the whole mucous membrane under which the capillaries lie. The vessels of the neck and body of the uterus pass along the sulcus on each side of the vagina, and their branches encircle the canal in a most complex network. The vessels of the fundus, through the veins of which the blood passes by the liver back into the general circulation, communicate with those below by anastomosis. We can thus, through the vagina, influence directly or indirectly the whole pelvic circulation. We can so diminish the supply as not only to check congestion, but we can literally, by the use of hot water, starve out an inflammation. I know from my own personal observation that several of these injections a day, at 100° to 106°, will abort an attack of cellulitis if resorted to early enough, and their use persevered in, with the aid of rest and anodynes. These injections exercise a most beneficial effect on the reflex system by allaying the local irritation. I know of no better means for removing the nervousness and sleeplessness of an hysterical woman than a

prolonged hot-water vaginal injection, when administered by an experienced hand. These injections will frequently soothe a patient to sleep in less time than could be done by any anodyne in the pharmacopœia. To receive permanent benefit from their use, they must be continued until the patient is restored to health. They should be given at least once a day, and the best time is on retiring at night. The only position in which the patient can receive any benefit from them is on the back, with the hips elevated, as I have described. She cannot administer them properly to herself, and I know of no arrangement, by siphon or other means, which can take the place of an intelligent nurse. As the patient improves in health, the quantity of water can be diminished, and the temperature lowered until the injections are discontinued from daily use, but for some time they should be employed for a few days after each period.

In 1859 I first used tepid and then hot-water injections, in the treatment of a member of my own family; at that time and for years afterward cold-water injections, at a low temperature, were used by every one in the treatment of uterine disease. I continued to employ hot injections in my private practice until the autumn of 1862, when I was appointed to the charge of the Woman's Hospital. From that date to the present, in this institution, and in my private practice, nearly every patient coming under my care has been treated by this method, merely varying the quantity of water and the temperature according to the circumstances of the case.[1]

The patient will be in a better condition for getting out into the open air after we have lifted up a uterus with version, or prolapsed, by an instrument to aid in restoring the circulation through the organ. The general condition will, however, in all probability, yet admit of little local treatment. Beyond the vaginal injections, to which a little chlorate of potash, or any other remedy indicated, may be added, with a daily pledget of cotton saturated with glycerin, and introduced into the vagina, our treatment will be limited until we have directed our attention somewhat to the general system.

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*Death following the Use of Sponge-Tents.*

Dr. De F. Willard exhibited before the Philadelphia Obstetrical Society (*Am. Journal of Obstetrics*, Aug. 1874) the uterus of a woman who had died after dilatation of the cervix uteri by sponge-tents. The patient had been married for eight years, but had never become pregnant. At one time, however, she suspected pregnancy, from having a six weeks' intermission between two menstrual periods, followed by a discharge of clots.

Before marriage she was regular, but afterwards the menses were scanty and painful. After he had introduced a pessary to relieve a slight anteflexion, the menses became more profuse and less painful. Offspring being earnestly desired, he introduced a sponge-tent to dilate the cervical canal, which was very narrow. The tent slightly dilated the canal, but as it closed up again, he introduced a larger one, which dilated the canal to the size of the little finger. This gave neuralgic pains, which she bore badly, although a stout-bodied woman. On a Friday he removed this tent and introduced a smaller one. Contrary to

[1] The action of hot water in surgery, as a means of preventing hemorrhage, was first brought to my notice by the late Dr. Pitcher, of Detroit. He stated that for many years he had been in the habit, when operating, of applying to a bleeding surface sponges taken from water as hot as could be borne. His explanation was, that, after a clot had formed in the mouth of a dilated vessel, the continued application of heat caused it, on reaction, to contract so firmly on the clot that secondary hemorrhage could not occur. With his views of the action of heat, when continued, on the coats of vessels, and my own in regard to the condition of the circulation in the pelvis, came the first suggestion to my mind of its application in the treatment of uterine disease. I have been so thoroughly identified with this mode of practice, that it seems scarcely necessary to claim the priority. Certainly, no one in this country is on record as an advocate for the practice previous to myself; and, as far as I have been able to ascertain, the same is true in regard to the practice of gynæcologists abroad.

orders the patient worked the next day (Saturday) at the sewing-machine. On Sunday morning he found her with a tender abdomen, extreme pain, fever, etc. The tent was discovered in the vagina, having slipped out of the canal.

The patient was placed upon opiates and supporting treatment, but died on the ninth day.

On post-mortem examination a small amount of serous exudation was found in the cavity of the abdomen. The parietal layer of the peritoneum was covered with lymph. An abscess containing about an ounce and a half of pus lay on the left side of the uterus. There had been extensive inflammation of the pelvic viscera; probably, at first, peri-uterine cellulitis, and then general peritonitis.

In the discussion which ensued, Dr. Ellwood Wilson reported an analogous case. The patient was desirous of becoming pregnant; she suffered with painful menstruation from malformation of the neck of the uterus. He introduced a sponge-tent on a Thursday. Fearing insufficient dilatation, he introduced another on Saturday morning. This was left in until Sunday morning. She seemed so well that he gave her permission to go down stairs. She, however, not only did this, but in the evening went to church. In the night she had a chill—on Monday peritonitis set in—on Tuesday she died.

Dr. H. Lenox Hodge also had seen a fatal case. He thought the use of tents was more dangerous than the profession believed. His case differed from the others in this particular, that the patient had been kept perfectly quiet after the introduction of the tents. The dilatation was desired by her husband, himself a physician, to facilitate the diagnosis of a suspected tumour. The first tent was introduced on Saturday, the second and third on Sunday and Monday respectively. Before the removal of the last, she complained of acute abdominal pain, and died of peritonitis in four days after. An autopsy revealed a double ovarian tumour, with the Fallopian tube of the right side firmly adherent to the uterus.

Dr. Albert H. Smith remarked that the only fatal case which he could attribute to the use of a tent was one complicated with a morbid growth. In this case he had once dilated the uterus successfully, and removed the tumour with an écraseur. The tumour recommenced to bleed eighteen months afterwards. He dilated with sponge-tents, and scraped away the tumour, which was a soft mass, probably a fibroid degenerating into a medullary sarcoma. Peritonitis set in, and the patient died in three days. He never hesitated to use tents, even in his office. The great danger was from their repeated use, when the uterus is in such an irritable condition that septic matter is readily absorbed. He did not hesitate to use a second tent, but he feared a third. He always required his patients to use an antiseptic wash while the tents were being used. For sterility or for dysmenorrhœa he often put in a sponge-tent the day before menstruation, and kept it in throughout the flow.

Dr. Goodell had one case to record of death following the use of three sponge-tents. It was a case of intra-mural tumour, and whether the peritonitis was owing to the tents or to the manipulation with finger and sound by the five physicians present, he could not say.

He believed and thought that the history of fatal cases following the use of tents proved that it is not the first tent nor the first batch of tents passed into the cervical canal that does the mischief, but those put in at the second or third visit. The first tent irritates and congests the cervix; its removal abrades the mucous coat, and from this raw surface are absorbed the fetid discharges or septic material generated by the succeeding tents. Influenced by this opinion, he now first stretches open the canal by the uterine dilator, crowds in the largest sponge-tent possible, and then insinuates around it several small laminaria-tents. He thus tries to accomplish the necessary dilatation by one instalment of tents. The use of detergent vaginal washes during the presence of the tents he always enjoins upon his patients.

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### *On Incision of the Cervix Uteri.*

Prof. R. Olshausen, of Halle (*Volkmann's Sammlung Klinischer Vorträge*, No. 67, 1874), considers incision of the cervix uteri, or, as he calls it, bloody

(*blutige*) dilatation of the neck of the womb, a subject worthy of careful study, both because its employment is unavoidable, and because it may be dangerous if performed in unsuitable cases. Gradual dilatation of the cervix is chiefly applicable to cases of pathological contraction of the canal. One has generally to deal with the relief of the milder or severer forms of dysmenorrhœa, or with the removal of sterility. Or, as indeed most frequently occurs, the two affections coexist.

Dysmenorrhœa is divided into three kinds: that arising from mechanical obstruction, the congestive, and the ovarian. The "gouty" and "neuralgic" are considered questionable.

Bloody (*blutige*) dilatation is advocated only in that small class of cases under the division of obstructive dysmenorrhœa, where it is dependent upon the small size of the external os. Whether for relief of dysmenorrhœa or of sterility, the use of the knife is strongly deprecated in stenosis of the internal os, and in contraction of the cervical canal from some lesion of the mucous membrane. The operation may be followed with good results, not only when there is an absolute and distinctly pathological contraction of the external os, but also where the os is normal or nearly so. On account of the small dimensions and dilatability of the soft structures, it is exceedingly difficult to measure exactly the size of the external os, and to find out where the pathological narrowing begins. If the os be with difficulty discoverable by the finger, and if the sound, guided by a practised hand, repeatedly slip past it and at last enter with a jerk, it may safely be considered as pathologically contracted, and it is very rare to find this condition unaccompanied with dysmenorrhœa. The mere passage of an uterine sound, with a diameter of three or four millimetres, is not a proof that the os is not contracted.

If sterility coexists with distinct mechanical dysmenorrhœa, we cannot err in assuming that there is a pathological contraction of the external os. When the removal of sterility is the object, we may even go further and perform incision of the external os even when the mouth of the womb is quite normal. Even if a careful examination of the patient fail to detect any assignable cause for the sterility, conception may still be prevented, some unknown conditions coexisting with a normal degree of contraction of the os, which dilatation of the os might cure. The dilatation of the os by the first labour is favourable to subsequent conception; and this is further shown by the cases of women who have been sterile many years rapidly conceiving after the birth of the first child.

The assertion of West, that openings large enough to admit an uterine sound must be capable of transmitting spermatozoa, is disproved by repeated observations. How the semen enters the uterus, has not yet been made out. That conception may occur without complete sexual intercourse, is true in exceptional cases; but the conformation of the organs, the relation of the bodies one to the other, both in man and the higher animals, during the sexual act, clearly shows that the male organ should come into contact with the external os uteri.

Olshausen strongly disapproves of bilateral hysterotomes as dangerous in practice, although apparently perfect in theory. He recommends Marion Sims's blunt-pointed bistoury. The blade should be passed up as high as desirable, and a cut made from above downwards, first on one side of the cervix and then on the other. The external os should then be deeply divided, so as to leave a gaping slit. On this latter point he lays great stress, as the tendency for the parts to unite is very great. The lips are best kept apart and prevented from uniting by tearing the adhesions down with the finger every twenty-four or forty-eight hours, and afterwards applying solution of perchloride of iron or the hot iron. Sponge-tents are condemned as liable to produce septicæmia. Laminaria tents are less objectionable. Before operating, care should be taken that no perimetric inflammation is present.

In sterility, where there is slight anteflexion with a concentrated external os, the ordinary lateral operation has seldom proved successful. The operation in these cases is modified by cutting a wedge-shaped piece out of the anterior lip.

In cases of severe catarrh of the uterus, it is advised to perform the bilateral

operation, as the wider and larger the orifices are, the easier is internal medication; still on account of the danger, it should be strictly limited to the most severe forms.

Finally, incision of the cervix must be accepted as an established therapeutical remedial measure, requiring, however, the greatest care in the performance and in the after-treatment. The author believes it is too frequently performed for trivial affections, and in a most reckless way. Such practice he cannot too strongly condemn, as most unjustifiable.—*London Medical Record*, March 18, 1874.

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*On Pyometra and Pyokolopos Lateralis from Abrasion of a Rudimentary Vagina, in a case of Uterus Bicornis.*

Dr. Otto Braus (*Berliner Klinische Wochenschrift*, March 9 and 16, 1874) reports a very interesting case occcurring in the practice of Professor Spiegelberg. The person was twenty-six years old. She began to menstruate at fourteen. The catamenia continued regularly for a year and a half: then there was an arrest for six months, during which time she began to suffer from pressure on the rectum and bladder. On the return of the catamenia, this still continued. A tumour was made out by the medical attendant, and opened. No fluid came away, and she obtained no relief.

Another medical man was consulted, who punctured the swelling and evacuated a quantity of dark, syrupy blood. This gave immediate relief, and she continued quite free from all trouble until her marriage, which was about a year and a half before she came under the observation of Professor Spiegelberg, when she began again to suffer from pressure on the bladder and rectum, accompanied with dysmenorrhœa. She became pregnant nine months after marriage, and miscarried at three months. On her recovery she noticed a puriform discharge, which increased in quantity and became offensive. Whenever it stopped, she at once experienced discomfort in the bladder and rectum, with a forcing down of the womb. On examination, Professor Spiegelberg found a movable somewhat irregular elastic swelling, larger than a fist, situated in the front and towards the right side of the pelvis; it reached slightly above the anterior wall of the pelvis, and caused the anterior vaginal wall to project downwards. The cervix was pushed backwards and to the left, and discharged a copious purulent offensive matter. The uterine sound passed the normal distance to the left. As pressure on the tumour increased the flow from the os, the uterine sound was again passed with its point turned to the right. About two centimètres up the canal it slipped into a roomy cavity. A blunt-pointed bistoury was passed up the cervix, and an opening about an inch long made. The sac was emptied of a quantity of pus, and small stony hard blood-concretions. A distinct entrance into the left horn of the uterus could be felt; and about a centimètre and a half above the os a fleshy septum with a free border.

This relieved, but did not cure, the trouble. The sac was then slit down to the bottom with scissors. Upon examination, a right and a left inner os could be distinguished. The walls of the cavity had all the characters of vaginal structure. Per rectum, the bicornate uterus could be easily defined; the uterine sound passed four centimètres into the right horn. It was a case of uterus bicornis, with a cervix in common. The history proved that it could neither be a hæmatocele nor a cyst, the result of an abscess from parametritis.

The reporter of this case relates two somewhat similar instances occurring in the practice of Professor Breisky. One patient was a woman twenty-five years old, the other was thirty-eight years old. The latter had borne four children before any urgent symptoms arose to attract attention. In both were the tumours slit up, and the patients made excellent recoveries. The diagnosis is not easy. It was not until the cavity was opened, and the free border of the septum was felt by the finger, together with the point of bifurcation per rectum, that Professor Spiegelberg could be certain what he had to deal with. He was not a little indebted to the cases reported by Professor Breisky for coming to a right conclusion. It was not until the sac was emptied that the bifurcation of the cervix could be felt.—*London Med. Record*, May 13, 1874.

## Medical Jurisprudence and Toxicology.

### *Poisoning by Colchicin in Beer.*

Practising-physician Böttern, of Fauborg, presents (*Hospitals-Tidende*, March 18, 1874) the following report of this case:—

In the *Archives of Pharmacy and Technical Chemistry* for January, 1874, is to be found an article wherein the extent to which the consumption of *Colchicum autumnale* has increased of late years is pointed out; and Dr. Spiesz, of Frankfort, makes the remark that, while the manufacture of beer has quintupled during the last ten years, the profit from hop products has remained almost stationary. As it has been proved by chemical analysis that the alkaloid colchicin, contained in *Colchicum autumnale*, is used as a substitute for the bitter principle of hops, it is reasonable to suppose that colchicum is to a very large extent employed to adulterate beer. That such an adulteration is practised I have lately experienced, and shall in consequence communicate the following facts:—

On February 24 of the present year, four gentlemen, including myself, supped in the evening at a friend's house, and at supper were treated to English beer. About a quarter of an hour after our repast we all began to feel unwell, with oppression in the region of the stomach and frontal headache. Shortly afterwards three of us were seized with violent retching, which was repeated in the course of the evening, and to which in my own case was superadded a profuse watery diarrhœa.

Our attention was directed towards the beer, when the servant-maid, who was in a similar predicament, declared that she had that evening taken nothing except a little of the beer which was left. The fourth of the party was for the first time seized with vomiting later in the evening; and in one case the retchings continued through the night, whilst the rest of us slept well. Immediately after an attack of vomiting we felt much lighter, but the sense of oppression soon returned, and then the vomiting recurred. Before we separated in the evening we drank a strong cup of coffee; subsequently we felt well. Next day we were all indisposed, with a sense of oppression in the gastric region, a burning heat in the head, thirst, and shivering fits; in one of the party rheumatic pains in the back and limbs were experienced. In my own case, towards the evening of the 26th, an abundant crop of lichen came out on the face, spreading over the whole body. But after five days it commenced to disappear under the use of warm baths and the mineral acids. My condition has in other respects, when I except the inconvenient itching and occasional shivering fits, been good, and the digestion in order. The servant, who was in the sixth month of pregnancy, still feels some heat in the head, and has occasional vomiting—symptoms which have not since appeared in any of the rest of us.

The beer was sent in casks from England, and was bottled in this town. Each of us drank only a small tumbler of it, and the servant finished what was left in one of the glasses. The beer was rather muddy, and had a somewhat flat, but not an acid taste. I presume that the bottle from which we drank was one of the last in the cask, to which fact are due the muddy appearance and the strong action. Our host and a lady, who had latterly drunk small quantities of the same sort of beer, have occasionally suffered from slight frontal headache and cardialgia, with nausea, without being able to account for these sensations.

The symptoms we were subject to on the evening of February 25 presented some similarity to poisoning by arsenic or copper; but it at once occurred to me that, as the beer was imported, it had been largely adulterated with one of those modern substances—picrotoxin or colchicin. With the kind assistance of Apothecary Berg and Candidate-in-Pharmacy Dons, colchicin was proved to exist both in the beer which was still in the bottle we had drunk of, and in that contained in several other bottles.

Excepting Dr. Warncke's communication in No. 6 of the sixth annual volume of the *Hospitals-Tidende*, I have nowhere found a case of colchicum-poisoning

recorded. Dr. Warncke's case was very much more serious, which may be attributed to the more concentrated solution, and possibly the non-indigestion of food beforehand. The preceding meal and the speedy vomiting were in our case very important elements, so that in the course of a few days it is to be hoped we shall be perfectly recovered from the ill consequences detailed.

That this was an instance of poisoning by adulterated beer is beyond all doubt, and I trust that these communications (Dr. Warncke's and the present one) may possibly tend to the exercise of some control over imported beer.

Messrs. Berg and Dons intend to communicate to a pharmaceutical journal the mode of proceeding in the analysis of the beer.—*Med. Times and Gaz.*, May 16, 1874.

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### *On Poisoning by Blistering Collodion.*

Dr. Ernest Schwerin communicates to the *Berliner Klinische Wochenschrift* for November 3, 1873, a case of cantharides poisoning, the subject of which was a rather hysterical female, aged twenty-three, who had menstruated twenty days before, and, except for some nervous attacks, was in good health. A dispute with her mother threw her into a violent fit of hysteria. Her mother, in great alarm, seized a bottle which she supposed to contain a preparation of ether and valerian, and gave her fifteen drops or so on sugar. It was, however, a blistering collodion which she had taken, prepared by macerating one part of blistering fly with one of ether. The first effect was to relieve her, but in about an hour there was violent pain at the epigastrium, then cramps, and constant inclination to pass urine, with pains in the hypogastrium. Dr. Schwerin saw her about six hours afterwards. The patient was then trying to pass urine every minute; there was at times a sort of cataleptic condition, with glazy eyes, small pulse, and repeated vomiting. Opium, camphor, poultices, and almond emulsion were prescribed. Next day the urine, though free from blood, was highly albuminous. The tongue and throat showed signs of irritation. These symptoms continued slightly for two or three days. On the fourth day the urine was free from albumen, and the patient convalescent. There were never any erotic symptoms. Dr. Schwerin concludes from this that the old view of the aphrodisiac action of cantharidin is incorrect, and that Pallé (*Journal de Brux.*, li. Août, 1870) is justified in expunging it from the list of aphrodisiacs.

Dr. W. Bathurst Woodman has seen some cases of poisoning by cantharides; and, although all symptoms of eroto-mania were absent in some, males as well as females, in others this symptom was well marked. Doubtless much depends on the dose, and on the physical and psychical condition of the patient. In Dr. Schwerin's case the dose must have been very small. The true explanation of the discrepancy may perhaps lie in the fact, that cantharidin stimulates the whole genito-urinary tract, but that the urinary organs suffer most, and in some cases bear the whole brunt of the battle. There is a naiveté and straightforwardness in the narrative of some of the older cases, which has the ring of genuine metal about it. The curious reader may consult the cases by Duprest-Rony, Dr. Chauvel, Ambroise Paré, and others, quoted by Sonnenschein in his *Handbuch der Gerichtlicher Chemie*, p. 266. There is also recorded in a somewhat scarce book called *Anecdotes du* 18me *Siècle*, printed at London in 1785, an account of a ball given by M. le Compte de Sade, at which cantharides were mixed with the viands—particularly with some chocolate bonbons. This, although valueless as direct evidence, shows at least the current views of the day on the subject; it states: "tous ceux qui en avoient mangé, brûlant d'une ardeur impudique, se sont livrés à tous les excès auxquels porte la fureur la plus amoureuse; les femmes les plus sages n'ont pu résister à la rage utérine qui les travailloit. Plusieurs personnes sont mortes des excès auxquels elles se sont livrés dans leur priapisme effroyable, et d'autres sont encore très-incommodées" (p. 214).—*London Med. Record*, May 27, 1874.

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## CLINICS.

### CLINICAL LECTURES.

*Abstract of a Clinical Lecture on Sciatica and its Treatment.* By FRANCIS E. ANSTIE, M.D., Physician to Westminster Hospital, etc. (Concluded from p. 135.)

Brief and imperfect as this account of the pathology and causation of sciatica has been, it will suffice to indicate at any rate a more rational scheme of treatment than those which are adopted by routine practitioners. If we are to take first the varieties of the disease in which there is the most decided indication for treatment, we shall certainly begin with the syphilitic; and here I wish to repeat the caution already given as to not accepting too readily the idea that syphilis is out of the question. You will be most tempted to make this mistake when your patient is a lady of good character. But remember that she may have been infected by her husband, and that this may have happened (in conception) without the occurrence of any primary sores. Inquire carefully in such cases for any history of eruptions or sore throats, but especially ascertain whether there have been any abortions or still-births. Where the patient confesses that there has been chancre, you must not give up the syphilitic hypothesis simply because a number of years have elapsed with few or no recognizable symptoms of constitutional infection; this is a point which has been copiously illustrated in the valuable researches on syphilitic nervous diseases

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generally which have been going on during the last twenty years. The line of treatment is quite simple. You administer iodide of potassium in rapidly increasing doses till you reach as much as from sixty to one hundred and twenty grains of the drug, or even much more, in each twenty-four hours. This very rarely fails to produce a rapid and complete cure; but if it should prove ineffectual you may resort to the bichloride of mercury, sixty to eighty minims of the liquor ($\frac{1}{16}$ to $\frac{1}{12}$ grain) thrice a day. Very often it will be advisable to give cod-liver oil at the same time.

In the few cases of clearly rheumatic origin, also, we get a clear indication for treatment: the use of iodide of potassium with bark will usually be found to remove the inflammatory enlargement of the nerve, and give speedy relief to the pain. The prolonged use of Kreuznach or Woodhall Spa water is desirable, in order to render the cure complete and permanent.

In the cases where we have reason to believe that the conjunction of the gouty with the neurotic temperament is exercising a pernicious influence, the chief practical deduction must be that the patient should very sedulously avoid beer and all saccharine wines, and should be very moderate in his total allowance of food, especially of meat and other distinctively nitrogenous foods. The careful and prolonged use of Vichy or Neuenahr water may do great good.

But, after all, the gouty, rheumatic, or syphilitic sciaticas form but a small proportion of the mass of cases which may be encountered in practice. The important question in dealing with ordinary sciatica, is—What am I to do with a disease which is essentially a neuralgia, but which is influenced by the special circumstances connected with the anatomical position and the functions which belong to the sciatic nerve?

In dealing with sciatica as a neuralgia pure and simple, we are fortunately provided with means which will give such immediate relief as will greatly solace the patient, and inspire him with that faith in his ultimate recovery, which is always so valuable to the sick, and especially to the nervously sick. I have already explained how necessary absolute rest of the part is, and you will commence your treatment by arranging a proper couch on which the patient is to lie all day, and by making him understand that he is not merely never to put his foot to the ground (except for absolutely necessary purposes), but that he should always lie either prone on his face or (for a few minutes' change) on the opposite side to that affected. If he be in pain at the moment of your first visit, I advise you to give him a hypodermic injection of one-sixth of a grain of acetate of morphia on the spot. All this is only preliminary; it gives you time to look about you, and deliberately select your line of treatment.

In dealing with simple neuralgias there are four possible main classes of remedies —1, constitutional, which include the regulation of diet and the employment of such medicines as are, in fact, supplementary aliments; 2, the removal of obvious sources of possible irritation; 3, the narcotic-stimulant medicines; 4, local applications.

1. As we are not dealing now with gouty sciatica, what I have to say concerning alimentary treatment is mainly in the direction of insisting on a very nourishing diet, and especially the use of fats, beginning with cream, and going on to cod-liver oil. To this we may add the use of iron or arsenic, or both, in anæmic cases.

Dr. Lawson has correctly pointed out that sciatica is sometimes connected with an acid dyspepsia and a tendency to pyrosis. I believe that these cases are less common than he supposes, and that they are mostly found in those who happen to be the subjects of gout as well as of sciatica. At any rate, wherever such symptoms are found they should at once be met by the administration of effervescing alkalies, with small doses of quinia —say a grain of quinia in four ounces of Vichy or of Apollinaris water three times a day. The quinia is here given simply as a restorer of the digestive tone, not with any idea of producing a specific effect upon the neuralgia.

The only cases of sciatica in which quinia is likely to produce specific effects

are those in which malaria is the exciting cause, and these are (in England) so rare that I have for practical purposes disregarded them. It is enough to say, here, that when we do encounter such cases we must treat them with the same full doses of quinia, administered before an expected paroxysm, as we should employ in ague itself.

2. The removal of obvious sources of possible irritation refers chiefly to two things. *Cold* should be guarded against by making the patient wear (night and day) a pair of thick flannel drawers. Intestinal irritation should be guarded against by thoroughly evacuating the intestines; it is best to do this by means of a good stimulant enema (ol. ricini, ℥ss; ol. terebinth. ℥ss; gruel, Ojss) thrown high up.

3. Of the narcotic-stimulant remedies, morphia, hypodermically injected, is much the most frequently useful, though it is scarcely that panacea for the disease which some have represented it to be. When I tell you that it can rarely be judiciously omitted in the early treatment of sciatica, I am very anxious that you should receive that statement in a reasonable way. The supreme utility of hypodermic morphia is due to the certainty with which (in moderate dose) it will cut short the pain without inducing narcotic depression. Pain is a complex and mysterious phenomenon, and among the many interesting facts concerning it is this—that the long continuance of pulsation, so to speak, of more or less rhythmical agony has a peculiar shattering effect upon the nerve, which leaves it *far more liable to pain than before*. Therefore you will do wisely to prevent, at any necessary cost, the patient from ever having more than a few minutes of acute pain at a time. This can usually be accomplished by immediately using the hypodermic syringe when the attack commences; and at this period of the illness you may even give one-sixth or one-quarter of a grain twice in each twenty-four hours, if necessary. But you are on no account to look upon hypodermic morphia as other than a temporary expedient to gain time for the recuperative powers of the system, aided by appropriate tonics, to conquer the morbid tendency.

4. Of local applications for sciatica (or any other neuralgia) some are used with one intention, some with another. *a*. There is a class of local remedies, the sole action of which is to shield the terminals of the nerve-twigs from irritation by paralyzing their sensibility; the result being that the nerve and nerve-centre enjoy comparative repose while the influence endures. Veratrine ointment is one example; aconite liniment another. In using the former, you will do well to employ, at first, an ointment only half as strong as that of the Pharmacopœia (four grains to one ounce, not eight), or, if your patient has a delicate skin, you will produce inflammation and pustulation instead of simply numbing the nerves. Lin. aconiti, applied with a broad paint-brush, is more convenient and more certain, but very expensive where it has to be applied over a large surface.

*b*. Mild stimulation of the nerve is, however, on the whole, by far the most satisfactory local method of treatment. This is done in two ways, either by blistering or by the use of the constant current. Blistering must always be used with precaution, and is almost wholly inapplicable to the irritable skins of *aged* patients. It is usually best to commence with the application of a blister, not directly to any of the painful points, but by the side of the spine at the junction of the lumbar and sacral portions. When the epidermis has been well distended with serum, the bladder is to be pricked with needles and drained of fluid without breaking the skin at all. If the malady prove at all obstinate, a series of these "flying" blisters placed successively near to (not actually upon) the foci of greatest pain will prove highly serviceable.

But in no instance of sciatica ought we to allow the pain to continue very long before putting in action a remedy which has approved itself in the hands of some of the best observers in Europe, of the highest value for sciatica—I mean the constant battery current, a remedy so powerful (particularly in this form of neuralgia) that, but for the expense and

trouble attending its use, it should be employed as the sole treatment in three-fourths of the cases of sciatica. It is absolutely necessary to have a good instrument, such as Weiss's or Stohrer's constant-current machines. From twenty-five to thirty-five cells will commonly be required, and the best method of application, on the whole, is the following: The negative pole (the poles are broad moist sponges) is applied as nearly as possible opposite the roots of the nerves which form the sciatic, and the positive pole is applied in succession to the several foci of pain. The poles should be kept continuously applied for about three minutes at each of these situations, and this should be done either once or twice daily.

The prognosis of sciatica depends mainly upon the age of the patient, in the true physiological sense, and on the length of time during which the malady has already lasted. Eulenburg speaks of it as among the most curable of neuralgias, and so it doubtless is—in favourable circumstances and with the adoption of all proper remedies. But it may be rendered utterly intractable, either by the failing nutrition of the organism in the stage of bodily decline, or by the carelessness of the patient, or of the doctor, in not strangling the disease at an earlier period in younger subjects. No disease with which I am acquainted offers more opportunity for medical energy to find itself rewarded, or for medical supineness to incur not undeserved discredit.—*Med. Times and Gaz.*, June 18, 1874.

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### HOSPITAL NOTES AND GLEANINGS.

*Nervous Disorder from Constipation; Relief by Purgatives.*—A married female, aged 28, and having two children, one four years old and the other ten months, under the following circumstances, applied for relief to Dr. Lockhart Clarke, at the Hospital for Diseases of the Nervous System. A few months ago she began to feel occasional headaches and giddiness, which increased so much that she was frequently afraid of falling. These symptoms were accompanied by great confusion of mind and depression of spirits, so that any little excitement would cause her to shed tears. Her friends stated that she was naturally very lively and intelligent. She said that she felt as if she could not answer correctly when she was asked a question; in fact her brain seemed, as she expressed herself, "to be in a muddle." Then her sight became affected, so that she was unable to read or do needlework; and soon it became so much impaired that she had difficulty in recognizing persons whom she knew well. At the same time, every object appeared double. At first, the distance between the visible objects was small, but gradually increased until it reached nearly a yard. The optic disks were quite healthy. About the same time she complained of a continual noise in her head, like "little bursts," as she expressed herself. There was also extreme drowsiness, so that she felt it almost impossible to keep awake, even amidst loud noise. When she presented herself, she had a stupid, heavy, and sleepy appearance. She was very thin, and had been losing flesh for the last few weeks. The bowels were always obstinately constipated, and had been particularly so lately. The abdomen was full and resisting. Under the impression that she might be suffering from the effects of nursing, her medical attendant had given her large quantities of quinia and iron, which, as she thought, made her worse. She was ordered five grains of calomel and eight of compound extract of colocynth at bedtime, to be followed in the morning by an enema, consisting of an ounce and a half of castor oil, one ounce of turpentine, and one pint of gruel, to be thrown forcibly up the bowels. The result was an enormous evacuation of fecal matter, containing numerous and very hard scybala. A decided relief of all her symptoms very soon ensued. The enema was repeated every two days for several times, and was followed each time by still greater improvement, until, at the end of a fortnight, all that she complained of had entirely disappeared. On inquiry, three months later, she was found to continue in good health. This is certainly a very instructive case.—*Brit. Med. Journ.*, Aug. 8, 1874.

*Fracture of the Vertex and probably also of the Base; Concussion; Complete Recovery.*—This case, which was admitted into Middlesex Hospital under the care of Mr. HULKE, shows the value of perfect rest and quiet in the treatment of injuries of the skull, and of taking precautions to keep the subsequent reaction within moderate limits.

J. B——, a servant girl, aged fifteen, was brought to the hospital on June 18th, at 1 A. M., having received severe injuries through falling from a first-floor window, which she was in the act of cleaning from the outside. She moaned, but was insensible, and bled from both nostrils. Pulse 72, small, weak. On examining the head after admission, an irregularity, as though the frontal bone were depressed, was found extending from temple to temple in the course of the coronal suture, the scalp in the same situation being very puffy. There was also a large puffy swelling above the right eye, the lids of which were, moreover, discoloured and so swollen as to prevent the exposure of the eyeball. No paralysis of arms or legs. Before admission into the ward the patient vomited several ounces of blood, and shortly after admission vomited blood twice. The urine, which was drawn off by catheter, was clear. No other treatment but perfect rest and quiet was adopted. At 9 P. M., the patient became more restless, groaning and throwing her arms about incessantly; the right eye and right side of the face generally were more swollen; there was also some twitching of the right angle of the mouth, which was observed to be drawn slightly to the right; no more vomiting. Pulse 100; temperature 99.4°.—12 P. M.: The puffiness of the scalp greatly increased, extending and diffusing itself over the forehead anteriorly, and over the zygomatic region laterally. Still restless and moaning; face rather flushed; respiration 36, short; no more sickness and no hemorrhage from nose and ears. Pulse 96; temperature 99°.

*June* 19. Pulse 96; temperature 98.6°. Was sick once early this morning, and once during the past night, the vomited matter being of a dark-brown coffee colour. General aspect much improved; appears partially conscious, and at times recognizes her friends. She slept a good deal during the day, moaning less, and only at intervals. Passes urine; skin hot and dry; no difficulty in swallowing; bowels not open since admission. Ordered three grains of calomel. Towards night vomited again, the vomited matter being less discoloured with altered blood. Still very restless and inclined to wander, but answered a question coherently. Pulse slow, weak, and irregularly intermittent; breathing easier and regular.

20*th*. Passed a very restless night, moaning at intervals. This morning pulse is stronger, 96; bowels still confined; skin cooler; temperature 98.6°. Only takes milk in the way of nourishment. Ordered another three-grain dose of calomel. There are now swelling and ecchymosis of the left eyelids and conjunctiva as well of the right. The late appearance on the left side is a noticeable fact (not until the third day), and Mr. Hulke was of opinion that it pointed to a fracture of the base. At 9 A. M., the bowels being still confined, a dose of senna mixture was given. Pulse 100; temperature 98.6°.

21*st*. A marked diminution of unconsciousness; asks for water to drink now and then, and has noticed some pictures on the wall opposite. Bowels were opened three times during the night. Pulse 96; temperature 98.6°.

22*d*. A decided improvement this morning; seems to take an interest in what is going on in the ward; asked for some flowers which were on a table near, and, in reply to a question, said she was better; eyelids less swollen; takes milk well, and expressed a desire for some meat. At 9 P. M. complained much of pain in the head and buzzing in left ear. Temperature 98.6°.

23*d*. Eyelids much less swollen; she can now open them pretty widely, disclosing greatly ecchymosed conjunctivæ; complains of pain behind right ear. Pulse 84; temperature 98.8°.

24*th*. Continues to improve, with the exception of persistent pain behind right ear; ecchymosis of left lids less, but of

conjunctivæ of both eyes the same; bowels open during the day. Pulse 86; temperature 98.6°.

25*th*. Ecchymosis of lids rapidly decreasing; that of conjunctivæ the same; is now able to open both eyes fully, and reads at times; pain in the right mastoid region continues; the countenance more tranquil; tongue less furred.

26*th*. Not quite so well to-day; pain behind ear more severe, but is lessened towards night: during the day she was quite lively. Pulse 80; temperature 98.6°.

27*th*. Very drowsy; tongue furred at sides; had rather a sleepless night; complains still of pain behind the ear and also over the vertex. Ordered an evaporating lotion to forehead, and an ounce of senna mixture, as the bowels had not acted since the 24th. Pulse 68; temperature 98.6°.

29*th*. Pain at top of head is gone, but that behind the ear continues; ecchymosis of conjunctivæ about the same. She was now put on ordinary diet, which includes six ounces of meat, besides bread, milk, potatoes, gruel, or broth.

*July* 4. Is entirely free from pain; ecchymosis of conjunctivæ very much less; sleeps well. Pulse 72; temperature 98.8°.

7*th*. Still progressing favourably; ecchymosis of eyelids quite gone.

16*th*. Fully convalescent; ecchymosis has entirely disappeared from the left conjunctiva, and almost from the right; is perfectly free from pain, and feels quite well: gets up.—*Lancet*, Aug. 29, 1874.

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*Cases of Administration of the Croton Chloral Hydrate in Intolerance of Light*, by Mr. BADER.

CASE 1.—Anne B., aged 18, was admitted into Guy's Hospital with corneo-iritis of both eyes and great photophobia. She commenced the croton chloral hydrate on December 24, 1873, taking five grains three times a day. Daturin of the strength of one grain to one ounce of water to be applied six times in one hour every evening. On January 16, 1874, all the intolerance had subsided; and on the 27th she was discharged, having had no return of the photophobia.

CASE 2.—Mary C., aged 11, was admitted with pannus with granulations. Commenced croton chloral hydrate gr. v three times a day on January 16, 1874. Her left pupil was very contracted, and intolerance was so great she could hardly bear to open her eyes. On the 23d, there being no improvement, the dose was increased to ten grains. On the 31st the dose was increased to twelve grains four times a day, after which she was slightly better. Slight improvement continued until February 14, when the dose was increased to fifteen grains three times a day. On the 16th she omitted the medicine purposely, and the next day was not so well. Medicine omitted altogether on the 24th, and greenstone applied to lids.

CASE 3.—Mary S., aged 19, admitted with corneo-iritis with great photophobia. Commenced croton chloral hydrate on December 24, 1873—dose, gr. v ter die sum. On January 1, 1874, intolerance had greatly subsided. On the 18th she could look at the light without flinching. On the 23d all intolerance had subsided, and she was discharged on February 2, without any return of the photophobia.

CASE 4.—Florence B., aged 8, admitted with corneo-iritis, epiphora, and photophobia. Commenced croton chloral hydrate gr. v ter die sum. on January 13, 1874. On the 17th was able to look at the light. Improvement continued until February 6, when she was not so well on account of the fog, which was very dense. Dose increased to ten grains ter die. On the 16th almost all the intolerance had subsided, so the medicine was discontinued. On the 18th she was not so well, so the medicine, five grains ter die, was again given, and on March 2 all the intolerance had subsided.

CASE 5.—Celia S., aged 24, admitted with closed pupils, ciliary redness, and photophobia, tension —1, the left eye being the worst. Commenced croton chloral hydrate January 13, 1874, gr. x ter die. On the 17th there was slight improvement. On the 23d she could look at the light with both eyes, but the left still continued worse than the right. On the 27th all the intolerance had subsided in right eye. On February 9 almost all

intolerance had subsided, and she went out of the hospital.

Case 6.—Mary D., aged 15, admitted with pannus with granulations and photophobia. Commenced croton chloral hydrate January 21, 1874, gr. x ter die. On the 23d photophobia had subsided considerably. On February 9 intolerance had greatly improved; dose increased to fifteen grains ter die. On the 14th there was very little intolerance. On March 2 medicine omitted, and lids touched with greenstone.

Case 7.—Ellen B., aged 7, admitted with corneitis and excessive photophobia. Commenced croton chloral hydrate gr. viij ter die, February 5, 1874. On the 9th there was a very marked improvement in the intolerance of light, which continued until the 13th, when the photophobia returned with increased severity. On March 2 there was no improvement at all. Medicine continued.

Case 8.—Clara S., aged 15, admitted with corneo-iritis and great photophobia, so that she could not bear the slightest light. Commenced croton chloral hydrate gr. x four times a day on February 10, 1874. On the next day there was a decided improvement in the intolerance. On the 13th she complained of great pain in the head, so the medicine was discontinued. On the 16th she again took five grains ter die, after which the photophobia gradually lessened, and on March 2 there was very slight intolerance.

Case 9.—Mary B., aged 49, admitted December 30, 1873, with closed pupil, intolerance, and neuralgia over forehead. Commenced croton chloral hydrate gr. xv ter die on February 6, 1874. On the 10th there was no improvement in intolerance, but pain in forehead was less. Increased the dose to twenty grains ter die. Intolerance did not subside, but pain in head grew less.

Case 10.—Julia B., aged 47, admitted February 28, 1874, with intolerance of light, but no ocular changes. Commenced croton chloral hydrate gr. xv ter die on March 1. She gradually improved, but photophobia did not entirely subside. Went out March 20.

*Remarks.*—It appears that only young people, and only those suffering from genuine syphilitic corneo-iritis, were benefited by the croton chloral hydrate. As regards the dose, I found that between five and ten grains was the most beneficial amount, although in one case I gave twenty grains four times a day without producing much good or any bad symptoms. All the patients complained of the nasty taste of the medicine, but in only one did it appear to produce any symptoms which caused me to stop giving it.—*Med. Times and Gaz.*, Aug. 8, 1874.

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*Case of Compound Dislocation of the Elbow-joint; Rupture of the Brachial Artery; Recovery.*—It is not our intention to discuss the accuracy of the statements of those who insist on the exclusive adoption of antiseptic methods in the treatment of cases of compound dislocation; but we cannot disregard the fact that such results as attended the subjoined case, though not of common occurrence, are not rare. The experience of many large hospitals, which still adhere to the older method of treating wounds, will be found to furnish ample proof of the success of simple treatment. In the following case no precautions were taken to purify the air surrounding the patient or to prevent its access to the wound. The dislocation was reduced and simple water-dressing applied, and yet the progress of the case was uninterruptedly good. If antiseptic treatment had been adopted, the success of the case would have been fallaciously attributed to the influence of the special mode of treatment.

For the notes of the case we are indebted to the dresser, Mr. Sincock.

A. B., aged eighteen, was admitted into London Hospital on October 18, 1873, with a compound dislocation at the right elbow-joint. When getting off the box-seat of the omnibus the horses started, and he fell, his arm getting entangled in the iron-work of the seat. The articular surface of the lower end of the humerus protruded through a lacerated wound at the anterior and inner part of the forearm. The dislocation was reduced by Mr. Sargeant, the house-surgeon, who, on discovering that the

brachial artery had been torn across, sent for Mr. McCarthy. The upper end of the artery could be distinctly seen pulsating at the bottom of the wound, the sheath of artery being tightly twisted and terminating in a fine point. The lower end of the vessel was not visible. There was no bleeding. There was, of course, no pulse at the wrist; but the hand and forearm were warm, and sensation was perfect. Under these circumstances, and as the lad was healthy, Mr. McCarthy considered that there was no immediate occasion for amputation; and that as the main vessel had been ruptured, excision of the joint might endanger the secondary circulation. He decided, therefore, to postpone any operative interference, and to be guided by the progress of the case. Water-dressing was applied, and the arm slightly flexed and supported by a pillow, the hand and forearm having been wrapped in cotton-wool. The progress of the case was uninterruptedly good; and at the end of eight weeks the lad was sent to the country with the wound healed, and his elbow-joint anchylosed at an angle of about 100°. A month later he returned to show himself. He had a good, useful arm, the arteries at the back of the elbow were considerably enlarged, and the only evidence of the interruption of the circulation was the condition of the nails of the right hand, which were each detached from the matrix.—*Lancet*, Aug. 8, 1874.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*Wounds of the Abdominal Cavity.*—Dr. D. N. Kinsman, Professor of Diseases of Women and Children in Starling Medical College, Columbus, Ohio, reports (*Clinic*, April 18, 1874) the following remarkable cases of recovery from abdominal wounds without untoward symptoms.

Wm. M., a stout young farmer, aged 23, was gored by a bull, August 19, 1871, The animal approached from behind, gave a thrust with his horn and threw him to the bottom of a ditch, when he could no longer follow up the attack.

On examination an hour after the injury, I found the patient cool and pale, with a small and frequent pulse, constant nausea and frequent vomiting of water, which he drank to quench a tormenting thirst.

There was a wound in the right lumbar region, three inches posterior to the antero-superior spinous process of the ilium. Into this wound I introduced my finger and was able to trace a bruised superior surface of the liver, more than an inch in width and as far as I could reach. In the wound was a string of tissue which I recognized to be the peritoneal investment of the liver, for it was still attached beyond the reach of the finger, and when spread out corresponded to the denuded surface of the liver. There was quite a free hemorrhage from the wound. I placed the patient on his right side, covered the abdomen with ice-cold compresses, administered grain doses of opium every hour, till pain was quieted, gave an unfavourable prognosis, and left. In brief, I attended this patient for six days, when he had become convalescent. For five days he was kept so profoundly under the influence of opium that the catheter had to be used daily.

This case is interesting, because it shows that under certain circumstances the peritoneum may be wounded by the worst kinds of instruments, blood may escape *ad libitum* into the peritoneal cavity, and yet the patient recover without an untoward symptom.

Mr. R., age 30. Was out on a drunken spree and got in an altercation with one of his friends. He was stabbed to the right of and superior to the umbilicus. The wound was three inches long. He fell upon the street, opened his pantaloons and laid wallowing in the street for some time.

When seen, there was a protrusion of omentum and small intestines as large as a quart basin. The structures which escaped were covered with sand and dirt, so that the colour of the parts was totally unrecognizable. The parts were thoroughly washed, returned, and the wound closed by interrupted sutures. The opium was given in full doses for a week. The wound healed readily, and the patient

recovered, and I suppose is still living. This case is even more remarkable than the first, for after such injury to the peritoneal surface, the case would seem hopeless.

Mr. L., with others, was out for a night of fun. The party became boisterous when a policeman attempted to arrest them. The whole crowd set upon the officer with slung-shots, and in the melee L. was stabbed in the abdomen. The wound was situated a little to the left, on the level of the umbilicus, and was one inch and a half in length. From the wound there protruded a small knuckle of the small intestine. There was little hemorrhage.

The wound was closed with interrupted sutures. Opium was given, and this case also recovered without peritonitis.

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*Sweet Oil as a Dressing for Wounds.*—Dr. Jos. W. Howe has recently introduced at the Charity Hospital, New York, ordinary sweet oil for the treatment of all kinds of wounds. It has several advantages over any of the other dressings in use, and apparently yields better results. The advantages are, that it keeps the air from the wound, and at the same time is a grateful dressing to the patient. It also promotes healthy granulations.

The mode of application varies with the variety of wounds for which it was intended.

In necrosis, after the sequestrum is removed, the cavity is filled with the oil, and a lint tent introduced. Every day the oil is renewed. In one case of necrosis of the lower jaw this procedure was had recourse to, and, shortly after, the patient was attacked with facial erysipelas, but, strange to say, the side of the face which had been operated on was not affected.

In incised wounds, the edges are brought together, and lint soaked in oil used as an external dressing.—*New York Med. Journ.*, May, 1874.

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*Sinus simulating Disease of the Hip-joint treated by Villate's Mixture.*—In the "Notes of Hospital Practice" in September No. of the *New York Med. Journ.*, the following case, which was treated in Bellevue Hospital, is reported.

The patient was a man aged twenty-five years, who had been previously an orderly in the hospital. He had received an injury to the hip by a fall, and from this an abscess developed, which opened and left a sinus, continuing for months. From the fact that there was pain both at the hip and at the knee, morbus coxæ was suspected, and the patient was placed in the wire breeches. It was decided, however, to try the effect of *Villate's mixture*, as an experiment. Injections, containing one part of the mixture to four of water, were applied to the sinus every third day, each injection being carefully washed out with water. After a week or ten days the thigh was very much swollen, and this was attended with considerable constitutional disturbance. This readily passed away, and it was found that the sinus had sloughed out, leaving a healthy granulating surface, which slowly healed.

The original formula of the mixture is as follows:—

℞.—Liq. plumbi subacetatis, ℥j.
Zinci sulphat. cryst.,
Cupri " " āā ʒss.
Aceti vini albi, fl℥vjss.

M. Dissolve the sulphates of copper and zinc in the vinegar and then add the subacetate of lead. Shake before using.

It is well to begin with a more dilute solution than was used in the present case, in order to avoid the risk of extensive sloughing.

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*Phytolacca Decandra in Mastitis.*—Dr. L. Alexander, of Yorkville, S. C., reports (*Atlanta Med. and Surg. Journ.*, Sept. 1874) two cases of impending mastitis successfully cured by fifteen drop doses of the fluid extract of phytolacca decandra every three hours.

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Obituary Record.—Died at Bethlehem, New Hampshire, on the 4th of Sept., at the age of 60 years, Jeffries Wyman, M.D., Hersey Professor of Anatomy in Harvard University.

Dr. Oliver Wendell Holmes, in an appreciative notice (*Boston Daily Advertiser*, Sept. 12, 1874) of the life and emi-

nent services rendered to science by Dr. Wyman, says: "We have lost in Prof. Wyman as nearly perfect a model of the student and teacher of science as we have ever known or are ever likely to meet with.

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"We say deliberately that a more beautiful and truly admirable character would be hard to find among the recorded lives of men of science. The basis of all was in his personal qualities, in his absolute truthfulness, his great modesty, his amiable disposition, his quiet enthusiasm, his inexhaustible patience. He never boasted, he never sneered, he never tired, he put forward no pretensions to infallibility, though he was never caught making mistakes, he was always exact and positive as to what he had seen, but willing to suspend his opinion however tempting a generalization might offer itself, if it was only probable and not proved. He was prompt to recognize the merits of those whom he considered in any way his superiors, generous in his estimate of his equals, and a willing helper of all those who looked to him for any kind of knowledge he could impart. In a word, he was always the same honest-minded, sagacious, unprejudiced, sweet-souled, and gentle-mannered creature of God, whom it was a joy to meet, a privilege to listen to, a regret to part from, whom it is a sorrow beyond words to lose, and whom it will always be a precious inheritance to remember."

## FOREIGN INTELLIGENCE.

*Treatment of Acute and Chronic Bronchitis and Asthma.*—Mr. Spurgin, resident medical officer to York Dispensary, employs iodide of potassium in these troublesome complaints (*British Med. Journ.*, Sept. 5th, 1874). He states, "I have tried iodide of potassium in over a hundred cases with almost invariable success; in fact, with such success, that patients have expressed themselves by saying, 'It has acted like a charm'; others have said that no medicine ever had any real effect upon their complaint before. Iodide of potassium has a marked effect upon the breathing, reducing the frequency of the respirations, perhaps (as I think) overcoming spasms. Almost after the first dose, patients have stated they have felt the medicine touch their complaint.

"I usually prescribe it with carbonate of ammonia, and, when the cough is very troublesome, add tincture of belladonna and ipecacuanha wine. In the above complaints I rarely give anything else but the above.

"In one case of very severe bronchopneumonia I tried iodide of potassium, with tincture of hyoscyamus and ammonia, and the respirations were quickly and astonishingly reduced from forty in a minute to less than half that number.

"In conclusion, I should add that I have purposely given a mixture containing ammonia, belladonna, ipecacuanha wine, spirit of sulphuric ether, etc., without iodide of potassium, and have not found much benefit; after which I have added iodide of potassium, and found the patient relieved almost at once."

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*Treatment of Malignant Pustule with Iodine.*—At a late meeting of the Academy of Sciences, M. Bouley presented a memoir by M. Cézard on what he terms the antivirulent method of treating charbon or malignant pustule, basing his theory on the experiments performed some short time ago by M. Davaine, illustrating the antivirulent properties of certain chemical agents. According to the author of this paper, iodine is considered the best antidote against the poison or virus of charbon or malignant pustule. Our author states that a dose of $\frac{1}{12}$th of a milligramme of iodine is sufficient to destroy the virulence of the fluid of malignant pustule, that is to say when mixed in a test-tube; but that it will take much less to prevent or even destroy the virulence of this terrible affection when the drug is introduced into the organism. M. Cézard informs us that an animal can support, without any inconvenience, the introduction in the blood, at one and the same time, of a quantity of iodine amounting in weight to more than $\frac{1}{5000}$th part of the entire mass of the blood, that is to say, more than is sufficient to destroy instantaneously the virulence of malignant pustule when this latter

exists, and to prevent its development when once the virus is introduced into the organism. Iodine, whether administered by the digestive tube or by hypodermic injections, is absorbed in substance and preserves its special properties even in the blood. M. Cézard advises that the drug be administered in the form of iodide of iodine, that is, in the proportion of one part of iodine to two of the iodide of potassium, which renders it more soluble in water and mitigates its irritating properties. This method of treatment, he continued, is very efficacious, not only against the true malignant pustule when it has attained the stage characterized by œdema, but also before it reaches that period, and even against the symptomatic fever of malignant pustule. M. Cézard also employs iodine locally in this affection in the form of subcutaneous injections of a solution in the proportion of $\frac{1}{500}$, and in the form of lotions, in the proportion of $\frac{1}{100}$ of the iodide of iodine. If there be a slough this should be previously excised, in order to facilitate the action of the drug.—*Irish Hosp. Gaz.*, Sept. 1, 1874.

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*Treatment of Mucous Polypus of the Velum Palati.*—A case is recorded (*Bull. Gén. de Thérap.*, t. lxxxv. p. 347) of this affection, by Dr. MÉPLAIN, of Moulins, in which a young man, 30 years of age, suffered from a small tumour of bright red colour, soft consistence, not pulsating, slightly pedunculated, situated at the junction of the hard and soft palate, a little to the left of the median line. Its duration had been about three weeks, and it had grown rather rapidly from the size of a lentil, when it was first noticed by the patient, to that of a bean, when Dr. Méplain first saw it. It interfered with deglutition and speech, and was liable to frequent hemorrhages after food had been taken. No cause could be assigned for its development. M. Méplain determined to treat it with repeated application of caustic, and for this purpose selected chromic acid, which he painted over its surface four days running. No improvement resulting, he next attempted to remove it with a pair of scissors curved on the flat; the hemorrhage was moderate, and was easily arrested with a compress moistened with perchloride of iron. In three weeks the patient returned with the tumour, which had reached its original size. On this occasion he seized it with a pair of dressing forceps, and endeavoured to tear it away. Moderate bleeding only followed, and this was soon stopped with a little acid gargle. Eight days after the patient again presented himself, and M. Méplain, somewhat discouraged by his failures, recommended him to try frequent application of carbolic acid. This was found to be very difficult, troublesome, and painful, but it appeared to check the growth of the tumour. Once more it was removed with the scissors, and once more it returned in the course of a week. Galvano-caustic he had not the means of applying, but he proposed the actual cautery, to which the patient strongly objected. He therefore at length determined to inject with acetic acid. He only threw in one drop with an Anel's syringe, but the effect was most satisfactory. The pain was acute for a short time, but the tumour gradually wasted away and did not return.—*Practitioner*, April, 1874.

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*An Hermaphrodite.*—We had recently an opportunity of examining an individual, of German origin, who presents a rare example of this malformation. He is now fifty-two years of age, and has exhibited himself at several scientific centres of Germany, before such men as Kölliker, Recklinghausen, Schulze, and others.

After a careful examination a doubt is left on the mind as to the sex; and, from the description given below, it may be suspected that we have here a sample of true lateral hermaphrodism.

The breasts present all the characters of the female sex, so that the upper part of the trunk has quite a feminine appearance. The generative organs, on the other hand, constitute an apparatus composed of parts belonging to both sexes. It appears as if the right side belongs specially to the male (and it is to be noted that the right side of the face looks masculine as compared with the left). In the centre a rudimentary penis is observed,

the glans of which is somewhat furrowed at its end. The urethra opens at the base of the penis forming a scrotal slit, this disposition giving rise to a variety of hypospadias. The prepuce is largely developed, very loose, and bound with a thick indented ridge, as is seen in the nymphæ. On the right side is seen the scrotum containing one testicle, whilst none exists on the left. The whole scrotum looks much like the labia majora, and when the finger is introduced between the two pendent halves and under the penis, it finds a cavity much resembling the vagina, though ending in a *cul-de-sac*. A female catheter, introduced into the meatus, and pushed horizontally (when the individual is standing), comes probably against a rudimentary uterus. When the catheter is directed upwards it passes into the bladder.

This individual regularly menstruated through the meatus urinarius up to the age of forty-four, so that it must be inferred that the ovaries are more than rudimentary. Doubts as to the reality of menstruation in this case were raised; but the testimony of Recklinghausen, Kölliker, and Scanzoni, who *saw* the function performed, is sufficient to settle the question. Hence we find, in the same being, the combination of the secreting organs belonging to both sexes. Spermatozoa have been found in the liquor seminis. The propensities of both sexes are thus observed in one being, and have, according to the individual's assertions, been satisfied.

The voice is more masculine than otherwise, and the chin presents some beard, which is regularly shaved. This hermaphrodite used to travel about Germany in women's clothes, and the descriptions written at the time refer to the phenomenon as Catherine Hohmann. Now, however, man's attire has been assumed, and seems altogether more suitable. Cases of true lateral hermaphrodism are extremely rare, and we have thus been led to dwell more particularly on the present case.—*Lancet*, Aug. 22, 1874.

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*New Researches on Diabetes.*—We learn that Dr. Pavy has obtained some experimental results which are likely to throw a new light on the subject of diabetes. He has found that the injection of defibrinated arterial blood into the portal system occasions a saccharine state of the urine. In one experiment, the urine after the operation contained fifteen grains of sugar to the fluidounce, and in others the quantity has amounted to nearly the same. In the counterpart experiment of injecting defibrinated venous blood into the portal system, the urine showed no signs of the presence of sugar. It thus appears that oxygenated blood passing to the liver causes an escape of sugar from the organ, and thence an accumulation in the system and discharge with the urine. It also appears that through the medium of the respiration of oxygen he has succeeded in inducing a sufficiently oxygenated state of the blood to similarly give rise to the production of saccharine urine. He has further found that through the agency of the inhalation of puff-ball smoke an immediate and strongly diabetic state may be induced, and that the effect is accompanied with such a modification of the circulation that the blood flows through the vessels, as is the case after section of the sympathetic, without becoming properly de-arterialized. His experiments, he considers, suggest that, in diabetes of the human subject, the blood, in consequence of vaso-muscular paralysis, is allowed to reach the portal vein in an imperfectly de-arterialized condition, and thus determines the escape of sugar from the liver. We understand his results are to be brought forward at the Royal Society as soon as its meetings commence.—*Lancet*, Aug. 29, 1874.

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*New Mode of Medication.—Injections into the Trachea.*—M. Gousett (de Bellesrue), in a communication made to the Biological Society, recommended that in low states of the system, where a rapid action was required, where absorption was almost extinct, and it was necessary to give medicines in larger doses than could be done by subcutaneous injection, medicines should be injected into trachea. He reported two cases of malignant fever in their last stages, which he successfully

treated by injection into the trachea of sixty-five centigrammes of chlorate of quinia.

M. J. recommends this mode of medication in tetanus, hydrophobia, and cholera. This mode of procedure is as follows: He introduces the trocar of an hypodermic syringe into the trachea one finger's breadth below the cricoid cartilage, and then slowly injects the medicine in solution into the trachea.—*Le Progrès Médical*, 28 May, 1874.

This practice will not be likely to find many followers.

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*Effects of Ozone on the Animal Economy.*—Prof. REDFERN read before the British Association for the Advancement of Science, a paper on this subject. A number of experiments were related in which animals were made to breathe oxygen mixed with ozone, and others made to breathe pure oxygen. The general result was that the respiration of oxygen with a 240th part of ozone for a very short time, say twenty seconds, is certainly fatal; that the same gas when resolved into oxygen is comparatively harmless, even when respired for long periods; that the death from the ozone is not due to a closure of the glottis, but to a congestion of the lungs, with emphysema and distension of the right side of the heart with a fluid or coagulation of blood, frequently attended by convulsions; that if the ozone be respired in a dilute form, animals become drowsy and die quietly from coma, the condition of the lungs being the same except that the emphysema is less marked; also, that animals that have respired oxygen more than twelve hours will now and then die suddenly from the formation of coagula in the heart, even after they have been in good health for some days.—*Lancet*, Sept. 5, 1874.

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*Composition of certain kinds of Food.*—Mr. J. W. COOPER read an interesting paper on this subject before the British Association for the Advancement of Science. Farinaceous foods, he said, were of the utmost importance to children and invalids, whose stomachs are too delicate to properly digest ordinary alimentary substances; and the upper and middle classes are in the habit of using with advantage considerable quantities of such preparations as arrowroot and cornflour. These substances, being in a minute state of division, break up easily and blend with water readily, and they make the food so gelatinous that the digestive juices can at once attack it. If large quantities of vegetable matter be introduced into the stomachs of delicate children, it becomes very difficult to digest; but there is nothing to prevent arrowroot, sago, and cornflour from being digested in the case of invalids and children, except in the case of children under nine months old. Excess of substances containing nitrogen has been known to produce diarrhœa in some children, as well as in grown-up persons. The nutritious value of starch foods has long been universally recognized. In India, China, Mexico, and other places, nine-tenths of the food consumed is mainly starch. In Ireland it furnishes 80 per cent., in the potato. In England our dietaries are apt to be too nitrogenous, and hence the great value and necessity for assimilative farinaceous food. A complete dietary has not yet been introduced to public notice in the form of food for adults, though Liebig did introduce a food for infants, devised upon chemical principles, to form a substitute for mother's milk, prepared from malt-flour, wheat-flour, cow's milk, bicarbonate of potash and water. Milk stands alone as a complete natural dietary for infants. The complex nature of Liebig's composition, which the author said does not appear to be much used in England, will afford some idea of the difficulties to be encountered in concocting a complete dietary; and, under these circumstances, it is fortunate, he observed, that the views of a chemist, which, if supported, were well calculated to prevent the use of most valuable and important foods for the sick chamber and the nursery, have met with such decided refutation.—*Lancet*, Sept. 5, 1874.

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*Proper Preparation of Food.*—Prof. REDFERN, in a paper read before the British Association for the Advancement of Science, "on the influence of food, and the

methods of supplying it to plants and animals," remarked that "there were few social problems more important than how to acquaint the wife of the labourer or artisan, or even the wives and servants of the middle classes, how to expend a fair share of their income upon food to the greatest advantage, and how to prepare it without destroying its nutritive properties. A savoury dish of meat was often prepared by mincing or cutting the meat into small and more or less cubical blocks. It was then stewed, or more frequently boiled; the outer surface of each little block has its albumen firmly coagulated, and the whole was converted into about as indigestible a mass as could well be imagined, the high-priced and highly nutritious meat having been destroyed for the purposes of nutrition, and the action of the digestive organs probably injured for some time to come. Or good and valuable flesh-meat was subjected to the process of salting, which first of all abstracted the juices of meat, and then hardened the fibres, so as to destroy or greatly deteriorate its digestibility. No doubt it was convenient to have a hardened dry mass of meat incapable of much change for months, and ready to be used for the purpose of filling the stomach and effectually satisfying the appetite; but these were not the purposes for which food was intended to be used. It ought to be capable of supplying the waste of the body, and of being easily converted into heat and motion. If it failed in these particulars it would also fail in nourishing the brain, and aiding in the evolution of intelligence, and thus intellectual and bodily power was lost to the community, and deterioration of race was promoted. His colleague Dr. Gordon said that he recollected running races, putting stones, wrestling, and other athletic exercises being the favourite amusements of the sons and servants of the farmers in the County Down. Now nothing of the sort was heard of. These young men found a short day's work almost too much for them, and at the end of it they were to be seen lying about indulging in idle conversation. Coincidently with this they imagined themselves the equals of their masters and mistresses, and that the healthful oatmeal porridge and buttermilk twice daily, with beans and bacon for dinner, was too strong and coarse; they insisted on more delicate fare, and demanded a supply of tea and white bread. They were unconscious that persons in their position but a few years ago possessed amazing vigour, and performed twice the amount of labour with greater ease, and when the day's work was over, actually revelled in the display of surplus strength which nothing but their better and more rational diet could have yielded them."—*London Med. Record*, Sept. 9, 1874.

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*The Separation of Acids from the Alkaline Blood.*—No satisfactory explanation has as yet been given to account for the separation of the acid urine and gastric juice from alkaline blood. We have recently, however, witnessed some experiments made by Dr. Ralfe in the laboratory of the Charing-cross Hospital, which promise to explain this seeming paradox.

This gentleman introduces an alkaline solution, consisting of bicarbonate of soda and neutral phosphate of soda, into a small U tube, fitted with a diaphragm at the bend, and passes a weak electric current through the solution. In a short time the fluid in the limb connected with the positive pole becomes acid, from the formation of acid phosphate of soda, the salt which gives urine its acid reaction; while the fluid in the limb connected with the negative pole increases in alkalinity. The changes effected in the solution are represented by the following formula:—

Bicarbonate of soda. Neutral phosphate of soda.

$$NaHCO_3 + Na_2HPO_4$$

Carbonate of soda. Acid phosphate of soda.

$$= Na_2CO_3 + NaH_2PO_4$$

To account for the formation of free hydrochloric acid in the gastric juice, chloride of sodium is substituted for the neutral phosphate of soda, the decomposition in this case being

Bicarbonate of soda. Chloride of sodium.

$$NaHCO_3 + NaCl$$

Carbonate of soda. Hydrochloric acid.

$$= Na_2CO_3 + HCl$$

The fact, that, from an alkaline solution containing salts like those found in the

blood, acids can be separated which are identical with those found in the urine and gastric juice, is extremely interesting, and of physiological importance.—*Lancet*, July 1, 1874.

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*Arsenical Poisoning by Wall-Papers.*—Dr. George Johnson, in an extremely able lecture published in the *Sanitary Record* of July 4th and 11th, collects some well-marked cases of arsenical poisoning, due to the wall-papers of rooms, his first three cases being in the persons of well-known physicians, whose sufferings were considerable, as the cause of them was unequivocal. Some of these cases are described in detail. The author goes on to show that the symptoms which are believed to have resulted from the use of arsenical wall-papers are similar to those which occur more or less constantly and severely amongst work-people who are engaged in the manufacture of arsenical pigments, or of the papers, artificial flowers and leaves, and other articles which are coloured with arsenical compounds. Dr. Johnson then proceeds to reply to the arguments of those who doubt the injurious effects of arsenical wall-papers, and who maintain that, if these papers were really injurious to health, their very general use for many years past would have caused numerous, and not rare and isolated cases of illness. To this objection Dr. Johnson replies by saying that probably many more cases of illness have resulted from the use of these papers than are known or even suspected to have had this origin. Then the quantity of poisonous dust thrown off from an overcharged arsenical paper is so small, that those only who are more than ordinarily susceptible suffer appreciably from the inhalation of the poison. In illustration of this, various examples of idiosyncrasy are referred to. A comparison is made between the symptoms caused by the inhalation of arsenical dust and those of "summer asthma, or hay-fever." Happily there are few individuals so sensitive as to have their eyes and nose and throat excited to inflammation by a neighbouring grass-field. Amongst workmen whose occupation compels them to breathe an atmosphere largely charged with arsenical dust, there are but few who do not suffer more or less seriously from the poison; but the comparatively small amount of poisonous dust which ordinarily floats in the air of a room hung with an arsenical paper has no appreciable effect on any but those who are peculiarly sensitive to the influence of the poison, a sensitiveness which may sometimes be shared by several members of the same family. The comparative rarity of these cases affords no reason for doubting their reality when they do occur, or the intimate relation between the symptoms and the inhalation of arsenical dust. The extreme tolerance of noxious influences displayed by some individuals is as remarkable and inexplicable as the high degree of sensitiveness manifested by others. Undoubted cases of poisoning by arsenical papers are common enough, and sufficiently serious to call for an energetic protest against the continued use of such papers; and it should be borne in mind that arsenic is often present, not only in bright green papers, but in pale green, gray, and even brown papers.—*London Med. Record*, July 15, 1874.

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Obituary Record.—Died, Aug. —— aged 80, Robert Edmund Grant, M D., F.R.S., Prof. of Comparative Anatomy and Zoölogy in the University College, London. Dr. Grant was by some considered as the English Cuvier, and his views with respect to many controversial points were in advance of his time, and in his works may be found foreshadowings of theories which have lately attracted much attention.

—— Aug. 1, 1874, in his 69th year, M. A. Cullerier, the representative of a name which for nearly three-quarters of a century has been illustrious in the special branch of surgery cultivated by its professors. Like his father and uncle, he was a successful practitioner and teacher, but for the last ten years he has been incapacitated by paralysis of the tongue. He is perhaps best known in this country by his great Atlas of Venereal Diseases, translated by Prof. Bumstead and published by Mr. H. C. Lea.

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There has long been an opening and a need for just such a work as the author here places before us—a thorough, complete, scientific treatise on Food and Dietetics in their physiological and therapeutical relations.—*Chicago Med. Examiner*, Aug. 15, 1874.

Dr. Pavy has for several years been well known as an investigator and writer on physiological topics connected with the great subject of nutrition, and his favorable reputation is sufficient to attract attention to the present work, which may be pronounced in advance the most thorough treatise in our language on the subjects treated. We frankly regard the work as deserving of great praise, both in its plan and in its execution, and sure to add to the already high reputation of its author.—*The New Orleans Med. and Surg. Journal*, Sept. 1874.

No modern treatise on this subject having existed in the English language, Dr. Pavy's work supplies a want which has been very seriously felt, and in a manner which shows that the author is an extensive reader and has judiciously arranged the numerous facts and theories, together with the most striking experiments and the deductions drawn therefrom. It seems to us that he has truly conferred a great benefit upon all interested in the subject-matter of his work, and that nobody will study its pages without having derived valuable instruction therefrom, and without considering it not only useful, but next to indispensable.—*Amer. Journ. of Pharmacy*, Aug. 1874.

Covering, as it thus does, a popular ground, it is a book which not only every physician who properly estimates the immense value of dietetics in therapeutics, but every educated person who wishes to retain his health, should possess and read.—*Amer. Journ. of Obstetrics*, Aug. 1874.

Now that it has appeared, the surprise is that it has not been done before. If we have waited long, we have a valuable work finally, one which will be appreciated by every intelligent reader in the profession or out of it, for all must feed, and most people desire to know all they can about the food they eat.—*St. Louis Medical and Surgical Journal*, Sept. 1874.

Much has heretofore been written on this subject, but never before has so systematic and thorough a result of mature thought and experience been given to the professional world. A perusal of the pages of "Pavy on Food" will amply repay all, but none so much or richly as the medical practitioner. It is to be hoped that every medical man in the country will avail himself of the opportunity offered of studying the subject thoroughly. No medical library can be considered complete now without a copy of Pavy on its shelves.—*Western Lancet*, Aug. '74.

It contains more information on the subject of which it treats than any similar English book, and it is certain to prove exceedingly useful to the medical practitioner.—*London Med. Record*, July 15, 1874.

On the whole, this work may be regarded as the best of its class in the English language.—*New York Nation*, Sept. 17, 1874.

It is the happy combination, in the manner we have endeavored to illustrate above, of sound modern theory with the otherwise somewhat dry details respecting the source, composition, and properties of the various substances which are or have been employed as articles of diet, that carries the reader through the by no means small volume before us, without any feeling except that he is gathering valuable theoretical and practical information on every page.—*Athenæum*, Aug. 22, 1874.

We may at once state that this is a book of first-rate merit, and that it handles its important subject in a manner which is especially valuable to the physiologist and to the medical practitioner, while on the other hand there are large sections of it that may be read with advantage by the public. We have long felt that there was scarcely anything more pressingly needed than such a book. Here we are obliged abruptly to stop, just as we seemed to have begun our remarks on this interesting book. After all, it is of little consequence, for every one should possess the work, and its merits will not be difficult to recognize. It is at any rate the best work in English on its subject, and deserves the close attention of all classes of society as well as of the medical profession.—*The Practitioner*, London, July, 1874.

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SUPPLEMENT TO

# THE MEDICAL NEWS AND LIBRARY.

No. 382. (*For List of Contents see last page.*) October, 1874.

## Anatomy and Physiology.

### *On the Anatomy and Histology of the Testicle.*

V. von Mihalkovics (*Bericht der Math.-phys. Classe der Königlichen Sachs. Gesellschaft der Wissensch.*, 1873), under the direction of Ludwig and Schwalbe, has investigated the course, structure, and contents of the seminal tubes, the interstitial tissue of the testicle, and the lymph-vessels and the bloodvessels of the testicle and epididymis. Besides those of the human subject, the testicles of the rabbit, guinea-pig, rat, mouse, dog, hedge-hog, boar, goat, bull, and several birds (pigeons, etc.), were examined. The paper is beautifully illustrated with several coloured plates. The author has arrived at the following conclusions:—

1. The convoluted tubules form a network by dividing dichotomously. The terminal branches arising from this division are connected together by loops. No bud-like dilatations of the wall of the seminal tubes are to be found in the cortical layer of the human testicle. The author thus disposes of the view that the convoluted seminal tubes arise by blind extremities, as supposed by Beale, Henle, Köllicker, and Sappey.

2. The tubuli recti are not simple prolongations of the contorted tubules, but excretory tubes, which lie in the tissue of the organ of Highmore and in the lower end of the septa. They are considerably narrower than the contorted tubules, and are lined with a low cylindrical epithelium.

3. Supporting cells (*Stützzellen*) and germinal nets (*Keimnetz*) are artificial products. They owe their origin to the coagulation of a tough substance, rich in albumen, which lies between the seminal cells. On the addition of hardening reagents, coagulation occurs, and a network appears between the seminal cells.

4. The interstitial cells are constituents of the testicle, whose analogues are also to be found in other organs (coccygeal and carotid glands, and corpus luteum).

5. The connective tissue of the testicle consists of finer and stronger bundles of connective tissue, which form networks and are enveloped by endothelial cells. The mesh-spaces are in many places bridged over by their endothelial membrane, which then passes over to and becomes continuous with the outermost layer of the seminal tubes, and also envelops the bloodvessels. These endothelial membranes consist of a wide-meshed trellis-work of exceedingly fine fibres of connective tissue, over which endothelial cells are stretched. Each such endothelial lamella possesses many fine openings.

6. The lymph-passages arise partly in the mesh-spaces of the connective tissue enveloped in endothelium, and partly in the spaces of the individual lamellæ of the walls of the seminal tubules. Proper lymph-vessels inclosed within tube-like walls do not occur in the parenchyma of the testicle. In testicles where the interstitial substance consists principally of cells, the primary lymphatics form free passages between their cells. From here the lymph flows into larger excretory passages, which are already lined with endothelium.

7. A capillary network of bloodvessels, lying in intimate connection with the membrana propria, is closely woven round the seminal tubules.

8. The epididymis is not only an excretory tube, but also the place for the secretion of the fluid constituents of the seminal fluid. The bloodvessels form

a dense capillary network in the non-muscular wall of the canal of the epididymis. This network lies immediately under the cylindrical epithelium, and presents a striking resemblance to the divisions of the bloodvessels in the ovarian follicle.—*London Med. Record*, May 27, 1874.

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*The Structure of the Mucous Membrane of the Uterus and its Periodical Changes.*

Dr. John Williams, Assistant Obstetric Physician to University College Hospital, London, presented at a recent meeting of the Royal Society of London a series of observations made on the uteri of nine women who had died in different stages of the monthly period.

In two of the uteri the menstrual flow had almost ceased, and the mucous membrane was wanting in the bodies of the organs. The muscular fibre-cells were more or less exposed in the cavity, and the meshes formed by their bundles contained glands and groups of round cells.

In one uterus menstruation had ceased three days before death, and the muscular fibres were not exposed in the cavity of the organ, but imposed upon them was a layer of tissue composed of fusiform and round cells. This tissue contained glands. The muscular tissue near the internal orifice was devoid of glands, but nearer the fundus it contained numerous glands.

In one uterus, in which the catamenial flow had ceased probably about a fortnight before death, the layer of superficial tissue was thicker than in the last; and near the internal orifice there was a marked and abrupt distinction between it and the subjacent muscular tissue.

In one uterus the flow had ceased three weeks before death, and the superficial layer was still thicker; and the distinction between it and the subjacent muscular layer was well marked, except at the fundus. The uterine glands were tubular, and arranged in some parts obliquely, in others perpendicularly to the surface. They were lined by columnar ciliated epithelium.

In two uteri menstruation was imminent, but the flow had not begun. In these the mucous membrane of the body of the uterus was fully developed, and had begun to undergo fatty degeneration. There was a marked distinction between it and the muscular tissue throughout the uterine cavity; it was highly congested.

In one uterus the menstrual flow had taken place for one day, and in another for two or three days before death. In these there was extravasation of blood into the mucous membrane, and the latter had in part been disintegrated and removed.

Menstruation appears essentially to consist, not in a congestion or a species of erection, but in growth and rapid decay of the mucous membrane. The menstrual discharge consists chiefly of blood and of the débris of the mucous membrane of the body of the uterus. The source of the hemorrhage is the vessels of the body of the uterus. The mucous membrane having undergone fatty degeneration, blood becomes extravasated into its substance; then the membrane undergoes rapid disintegration, and is entirely carried away with the menstrual discharge. A new mucous membrane is then developed by proliferation of the inner layer of the uterine wall, the muscular tissue producing fusiform cells, and the groups of round cells inclosed in the meshes of the muscular bundles producing the columnar epithelium of the glands.—*Obstetrical Journal of Great Britain*, August, 1874.

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*Accessory Lobe of Right Lung.*

E. W. Collins laid before the Royal Irish Academy, April, 1874, a specimen illustrating an accessory lobe of the right lung, taken from the body of a male subject, aged about fifty years, in the dissecting-room of the University of Dublin. The specimen presented a threefold morphological peculiarity as regarded lung, pleura, and azygos vein. An accessory lobe, measuring four inches in length by two and a half in breadth at its widest portion, sprang from

the angle between the root and the upper portion of the right lung, immediately above the bronchus. It was somewhat pyriform in shape, and rested upon the right side and front of the bodies of the five upper dorsal vertebræ, in an accessory pleural pouch. The pouch was formed by a duplicature, which depended from the cone of the pleura. It was continuous with the costal pleura externally along a line corresponding to the heads of the five upper ribs, internally along the mesial line of the five upper dorsal vertebræ. Between these points it arched over the accessory lobe, and isolated it from the remainder of the lung. It extended underneath the trachea, and invested the right side of the œsophagus. The azygos vein, instead of arching over the bronchus, arched over the peduncle of the accessory lobe, lying in the lower free margin of the pleural duplicature. This was the only specimen of the kind that had been noticed in Dublin, though seven similar cases had been recorded elsewhere. Stress was laid upon the suggestion of Prof. Cleland, made in this *Journal* (May, 1870), that an abnormal course of the azygos vein during the process of its development, whereby it drew down around it a pleural fold, and thus isolated a probably adherent portion of the lung, offered a satisfactory solution of the mode of formation of this accessory lobe. The author pointed out that a remarkable confirmation of this theory was to be found in an unique case recorded by Wrisberg of a similarly situated accessory lobe of the left lung, where the left azygos or superior intercostal vein preserved its fœtal condition by opening into the left vena innominata. The author regarded such a case as that described by Pozzi (*Report*, VIII. 174), and a similar one on the left side by Rektorzik, as merely higher developments of pulmonary notches. The paper concluded with an allusion to accessory bronchi in their connection with this subject.—*Journal of Anatomy and Physiology*, May, 1874.

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### *On the Act of Vomiting.*

Carl Greve (*Berliner Klinishe Wochenschrift*, July, 1874) says that, although the experiments of several physiologists, and especially those of Magendie, seem to prove that the stomach is entirely passive during vomiting, and that the expulsion of its contents does not depend in the least on the contraction of its walls, yet numerous others still assign to it a more or less active *rôle*. The existence of a nervous centre for the act of vomiting, its situation and the nervous communications connected with it, being all more or less uncertain, Greve undertook some experiments to settle the disputed question. He made use of apomorphia, which he finds to be the most certain and speedy of emetics, and accompanied by far fewer concomitant and subsequent effects than any other. Vomiting occurs after division of the vagi. The negative results obtained by Quehl in this respect were due to his having tied the dogs experimented on upon their backs, in which position they hardly ever vomit except when their stomachs are full. When dogs have emptied their stomachs in the morning by violent vomiting, they will not vomit in the afternoon when tied either upon their backs or bellies, but will do so at once if set free and an emetic administered. They vomit more easily when placed on their bellies than on their backs. After the injection of apomorphia apnœa cannot be produced; and, *vice versâ*, when vigorous artificial respiration is kept up, it counteracts the emetic power of apomorphia. The centre for vomiting is identical with or close to the respiratory centre. The nervous path along which the irritation is propagated from the vomiting centre to the organs concerned in the act, lies in the spinal cord as far as the sixth dorsal vertebra. When the cord is divided below this point vomiting still occurs, but not when the point of section is above this vertebra. The stomach takes no part whatever in the act of vomiting.—*London Med. Record*, Aug. 19, 1874.

## Materia Medica and Therapeutics.

### *The Action of Alcohol.*

From the extent to which alcohol is used as a food and as a medicine—to say nothing of its employment in intoxicating people, which, as we too often forget, means poisoning them—one would imagine that its place and power would have already been tolerably well settled, and its mode of action pretty well ascertained. Every-day experience shows us, however, that this is not the case; and very few, even among those who have paid most attention to the subject, are quite sure how much alcohol may be taken either by a healthy or by a sick man without injury, or what effect it will have when used in moderate quantities. We, therefore, gladly welcome the publication of such experiments as those which Dr. PARKES has lately communicated to the Royal Society.

The object which he had in view was to ascertain the influence of ordinary or ethyl alcohol on the temperature, pulse, and respirations of a healthy man. He obliged a healthy young soldier to take exactly the same amount of food and exercise every day for several days together, and carefully noted the temperature, pulse, and respirations. For the first six days, no alcohol was given; but on the following five days the soldier took a certain quantity of raw brandy every day. As his diet and exercise remained the same as before, any change in the temperature, pulse, or respiration, must be attributed to the action of the alcohol. He finished breakfast every day at 7 A. M., and then lay in bed till 2 P. M., when he rose and took exercise. At 9 P. M. he went to bed. The brandy was given at 11 A. M., four hours after breakfast. The first day he took one fluidounce of undiluted brandy (equal to half an ounce of alcohol); on the second day, two ounces; on the third day, four ounces; on the fourth day, six ounces; and on the fifth day also, six ounces.

The results of these experiments, and of others previously communicated to the Royal Society, showed that the temperature of the axilla and rectum was hardly altered by the alcohol. It certainly was never increased; and, though it seemed to be slightly lowered, this was not quite certain; and, if any lowering did occur, it did not exceed 0.35° Fahr., and may not have been more than 0.07° Fahr. In these experiments, the temperature had been raised by the food taken at breakfast-time, and had again begun to fall, the process of digestion being nearly finished. When alcohol was given during fasting and rest, it lessened the temperature much more distinctly, though still only slightly, the diminution never exceeding half a degree Fahrenheit. It was greatest one or two hours after the dose had been taken, and was evidently passing off after three hours. If given with food and either usual or increased exercise, alcohol produced no effect whatever on the temperature, even when the quantity amounted to so much as from four to eight ounces of absolute alcohol, equal to sixteen ounces of brandy, in twenty-four hours. In no case did it raise the temperature. When the man experimented on was at rest, the pulse was quickened from five to ten beats per minute after the alcohol had been swallowed, and remained quick for some time. When exercise was taken, the increase in rapidity was still greater. After the effect of alcohol had passed off, the pulse-rate fell even below the normal, so that the number of beats in twenty-four hours was not increased unless the amount of alcohol had been large and repeated. The pulse became fuller and softer to the touch; and it was evident, both from sphygmographic tracings and from the redness of the skin, that the radial artery and the cutaneous capillaries were relaxed and dilated. The respirations were not increased in number; in some experiments, indeed, they were lessened and became deeper, but the effect was not very marked. Alcohol, then, according to Dr. Parkes's exact experiments, has almost no action on respiration, and very little on temperature, which it slightly diminishes, but never increases. Its effect on the heart may be said to be stimulating, but not strengthening, and may reasonably be compared to that of a spur applied to a horse, quickening its movements for a time, but not actually increasing its strength as a feed of corn would do.

Such being the case, Dr. Parkes's results must induce physicians to consider most carefully to what extent stimulants are to be administered in disease; for every one knows that many a horse which might have reached its journey's end —at a snail's pace, it is true, but still safely—has utterly broken down on the road, in consequence of too frequent an application of the spur; and it is just possible that many a heart, which might have kept up the circulation feebly and languidly till the crisis of the disease was past, may have become exhausted and ceased to beat because it had been kept working beyond its strength for days or hours under the stimulus of alcohol. Whenever the circulation is becoming so weak as to be insufficient to sustain life, alcohol must at once be employed, and its beneficial powers will immediately become manifest; but the benefits to be derived from its administration while the power of the heart is still sufficient are rendered somewhat doubtful by Dr. Parkes's observations. It is, however, very difficult to apply the results of physiological investigations correctly to the treatment of disease; and the problems with which we have to deal are so complicated, that all our deductions must be checked by actual experience at the bedside. The slight effect of alcohol upon the temperature of the body in Dr. Parkes's experiments seems at first sight very extraordinary, especially when we remember the widely spread custom of men drinking spirits in cold weather to warm, and in hot weather to cool them. The conditions under which the experiments were made, however, afford a ready explanation of the result. The subjects of them were lying in bed both before and after they swallowed the brandy, and loss of heat from the surface of their bodies was, in all probability, prevented by the bed-clothes. Any change in the temperature of the body depends on a disturbance of the relation between the heat produced by it and that given off from it. If more heat be produced, the temperature will rise; and if less be produced, it will fall, supposing the heat radiated off or conducted away from the surface to remain the same. And, on the other hand, the amount of heat produced may remain unaltered, and yet the temperature will fall if the heat be abstracted more rapidly from the skin, and it will rise if heat be given off more slowly. The condition of the cutaneous vessels forms one of the most important parts of the great regulating mechanism by which the balance between loss and gain of heat is preserved in the organism. Whenever the temperature rises, these dilate, as we see in the flush of fever or after active exercise, and, by exposing the warm blood over a large surface to the influence of the air, with only a thin layer of tissue between, quickly cool it down, in somewhat the same way as we cool tea quickly by pouring it into a saucer. Cold has exactly the opposite effect; it causes the cutaneous vessels to contract, and thus drives the blood from the surface into the interior of the body, and prevents its temperature from becoming lower. The skin may thus become as cold as ice, but the vital organs are preserved from chill. Over the regulating mechanism just mentioned alcohol exercises a most important influence. As Dr. Parkes has observed, it dilates the arteries and capillaries, allowing the blood to stream freely through the cutaneous vessels, and imparting a ruddy tint to the surface. The consequence of this is, that a glass of spirits on a cold day allows the warm blood from the interior of the body to circulate over the surface, and imparts a temporary glow to the numbed extremities. But it only warms the outside at the expense of the inside; and the cooled blood, returning to the vitals, quickly causes a depressing chill to succeed the first feelings of comfort. So notably is this the case, that the gillies on a Highland moor will refuse a "nip" of whiskey, on the plea that it is too cold; and Arctic travellers unanimously denounce the use of spirits while exposure to cold continues. But the case is different after shelter has been reached, the wet clothes removed, and the individual once more seated by a warm fireside. The cutaneous vessels are slow to dilate after their long contraction, and so the blood cannot readily reach the surface, although warmth instead of cold is now applied to it. Consequently, it is a long time before the heat is conveyed to the interior; or, in other words, it is long before one becomes warmed through. If a little alcohol be taken at this stage, it materially hastens the process; it dilates the vessels; and the blood, no longer pent up in the interior of the body, circulates freely over the surface, and carries

the warmth of the fire back with it on its return. At the same time, the extra pressure of the blood on the internal organs is relieved, and the danger of congestion taking place in them, and leading to inflammations and catarrhs, is diminished; so that a dose of alcohol, under the conditions just mentioned, is popularly employed to prevent persons from catching cold. At the same time that the cutaneous vessels dilate, the activity of the sudoriparous glands is frequently increased, so that the surface of the skin may become covered with sweat, though previously dry. By the evaporation of moisture, warmth is rapidly abstracted; and, the blood being thus cooled, we can readily see why men drink on a warm day to cool them, as well as on a cold day to warm them. It is obvious that, when a person is neither exposed to cold nor heat, but is simply wrapped up in blankets, alcohol may alter the distribution of heat within the body, and cause the surface to become warmer by dilating the vessels. But, loss from the surface being almost entirely prevented by the woollen coverings, the temperature of the body as a whole cannot be much reduced by this means; and, as Dr. Parkes noticed a distinct reduction, we must look in some other direction for its cause. Besides, the fall did not attain its maximum till one or two hours after the alcohol had been swallowed; while dilatation of the vessels usually begins before many minutes have elapsed. Moreover, the fall was greater in persons fasting than in those whose temperature had been somewhat raised by food--the very reverse of what we would expect if it were simply due to more rapid cooling. These three circumstances point to diminished production of heat, rather than increased loss, as the cause of the fall in temperature. Professor Binz, of Bonn, has found that alcohol lessens oxidation in the organism. thus diminishing its calorific powers; and to this we must probably ascribe the results observed by Dr. Parkes. As alcohol lowers the temperature more during fasting than during digestion, it appears not improbable that it retards the oxidation of tissues more than that of the products of digestion. Should this be substantiated by further experiments, it will be of considerable importance with reference to the use of alcohol as a paratriptic. There are, however, many other points regarding the action and use of alcohol which require further elucidation; and, until they also are determined, we can hardly expect that the proper use of alcohol will be thoroughly understood. We, therefore, hope that Dr. Parkes will continue his observations, and examine the effects of alcohol on the digestive and nervous systems in the same careful, elaborate, and scientific manner in which he has already investigated its action on the circulation, respiration, and temperature.—*British Med. Journal*, April 4, 1874.

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### *The Physiological Action of Propylamine and other Derivatives of Ammonium.*

The *Comptes-Rendus de la Société de la Biologie de Paris* for 1873 (p. 246) contains an account of some experiments made by M. Laborde on the physiological action of the substances above enumerated, with especial reference to the great use which has lately been made of propylamine and its allies in France in the treatment of acute rheumatism. His results seem, as he himself remarks, to be but little in accordance with empirical views of their properties. The conclusions arrived at are as follows:—

1. Propylamine in the crude form, or trimethylamine, both act primarily on the central nervous system, especially its spinal portion, and produce, in physiological doses, excitement and increased functional activity of the cord, so as to react on the respiratory and circulatory systems, and to accelerate the heart's action. In poisonous doses depression follows this excitement, and at this period only (that is, if the doses are excessive) there is a retardation of the pulse and depression of temperature. Death results from cardio-pulmonary asphyxia. If trimethylamine be given to a dog by the stomach, it will be tolerated up to a dose of three grammes without vomiting, but by its local irritation catarrh of the mucous membranes of the stomach and duodenum is produced, accompanied by hyperæmia and superficial ulceration; and if it be

injected into the subcutaneous tissue it produces true sloughs. It can also give rise to hæmaturia from congestion of the kidneys.

2. The physiological action of chloride of trimethylamine is substantially the same as that of its base, but it differs from it by its slighter intensity, which scarcely attains that of half a dose of the other. Neither salt should be regarded as acting directly on the muscular tissues or as true cardiac poisons.

3. Trimethylamine and its chloride are in their physiological action on the nervous system rather analogous to the ammoniacal compounds in general, especially the chloride and acetate of ammonium; but while the latter salts even produce tetanic convulsions, trimethylamine and its chloride scarcely do more than produce muscular trembling and an exaggeration of the principal functions of the spinal cord.

Trimethylamine and its chloride (especially the former) are thus general functional excitants, and they rouse and accelerate the circulation more than they depress or calm it, for depression only succeeds large and long-continued doses, which injure the system by irritating the digestive and urinary organs. We cannot therefore look on them as true antipyretics, and they are also much inferior in respect of their exciting and stimulating action to the chloride and acetate of ammonium, and require to be given in much larger doses than the latter.

The trimethylamine was, in M. Laborde's experiments, injected into the dog's stomach by means of a sound, in doses of one to three grammes dissolved in fifty grammes of water, and the dose was repeated for twenty days.

Chloride of trimethylamine was injected into the dog's crural vein in five-gramme doses dissolved in fifty grammes of water, and chloride of ammonium was exhibited in the same way in a warm solution of from three to five grammes in forty of water.—*Med. Times and Gaz.*, Aug. 29, 1874.

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*General Remarks on the Internal Administration of Free Phosphorus.*

Mr. J. Ashburton Thompson (*British Med. Journal*, August 29, 1874), in a paper presented at the recent meeting of the British Medical Association, submitted the following propositions. The action of phosphorus varies strictly according to the form and dose in which it is given; thus, a stimulant, a tonic, or a poisonous action may be elicited at will. The stimulant power may be enhanced by an adjuvant. The choice of adjuvants is limited, the best being ether. The dose to be given for this purpose must not fall below one-twelfth of a grain, nor be repeated at any definite interval; but the quantity may be advanced to one-eighth of a grain, and is to be repeated as the occasion demands. The objects for which it is proper to employ phosphorus as a stimulant were described as being: preparation for unusual mental or bodily exertion; relief from the effects of such exertion; as a remedy for the typhoid state, especially in the specific fevers. From the use of a stimulant dose in calling forth the rash in the exanthemata, and its diaphoretic powers, an analogy was drawn between the power of a stimulant dose of phosphorus and a violent purgative (croton oil) to remove an uncomplicated acute attack of trifacial neuralgia occurring in an otherwise healthy subject. The formulæ appropriate to the kind of stimulation desired in special cases were referred to and exhibited. The tonic power of phosphorus was considered. The mode of administration and the dose to be given for this purpose were described. The dose was fixed at one-hundredth to one-twenty-fifth of a grain. The dose must be carefully regulated within the prescribed limits, since phosphorus is appropriate as a tonic in cases in which its stimulant action would be disastrous. The special powers of phosphorus as a tonic were described as being: to renovate exhausted nerve-function; and to reconstruct altered nerve-matter. The facts from which these powers were inferred were detailed. The aphrodisiac power of phosphorus was not evinced under ordinary circumstances; but only if either the patient's sexual power were in abeyance, or if the dose given was excessive. Sexual excitement was therefore one of the signs, if not of poisoning, at least that the dose in use was excessive.

*The Use of Quinia in Infantile Diseases, and especially in Hooping-cough.*

Dr. Rapmund, in an essay on this subject (*Deutsche Klinik*, 1874, p. 167), remarks that quinia and cold affusions are the remedies which possess the most certain and energetic antipyretic properties. Both are particularly useful in country practice, when the practitioner cannot have recourse to therapeutic agents of too complicated a character, partly on account of the difficulty of seeing his directions properly carried out, and partly on account of the stupidity of the patients. The chief objections to quinia are its cost and extreme bitterness. Its power over febrile affections is, however, very great. In 1872, Hagenbach, in the *Annales de Thérapeutique Infantile*, demonstrated that quinia acts not only in lowering the temperature and moderating the frequency of the pulse, but in shortening the period of convalescence. It is at once, he maintained, an antipyretic and a tonic. His observations were made on children arrived at the period of second dentition. Dr. Rapmund, on the other hand, chiefly observed its effects in much younger children, some being still at the breast. He administered quinia in four cases of scarlet fever, eleven cases of measles, two cases of smallpox, three cases of erysipelas, nine cases of lobular pneumonia, and three of follicular enteritis. Country practitioners know very well that parents do not send for medical advice in the ordinary exanthemata unless serious symptoms appear. In such cases he speaks in terms of praise of the immediate administration of quinia. Previously to its being given, the child has often been in his practice excited, sleepless, delirious, and the cause of great alarm to the relatives. But as soon as a sufficient dose had been taken, the temperature and the frequency of the pulse fell, and the children enjoyed a calm and prolonged sleep. This hypnotic effect is of the greatest importance in children, enabling them to recover their powers during repose. Its value has been particularly insisted upon by Professor Jürgensen in respect to the treatment of croupal pneumonia. Quinia has also a marked influence in rendering the march of febrile diseases benign. Vogel, in the *Dictionnaire des Maladies de l'Enfance*, has recently declared that quinia is the only remedy that has succeeded in his hands in erratic erysipelas; and Dr. Rapmund has been equally successful. The dose was about two or three grains per diem. The strength of the patient must be kept up, especially when the erysipelas spreads. The affection in which quinia is serviceable *par excellence* is the lobular pneumonia of infants, and Dr. Rapmund prides himself on having obtained seven successes out of nine cases. In this disease death supervenes in consequence of cardiac insufficiency due to the violence of the fever, and it is obvious that quinia is exactly adapted to counteract this condition. When the extremities are pale and cold and cyanosis has set in, quinia is useless; but in a less advanced stage, when the febrile symptoms are acute and the temperature and pulse are much above the normal, quinia is formally indicated, and under its influence not only does the fever diminish, but the thoracic symptoms improve. The number of respirations, which often rise to eighty per minute, falls to thirty or less; the nostrils cease to dilate, the contractions of the diaphragm become less painful, and the child becomes calm. In cases of hooping-cough, quinia appears to diminish the violence of the attack, and better rest is obtained at night; and it appears to prevent complications, and to render the course of the disease much more uniform and benign. Children should be well supported either by means of milk or by beef-tea. In very feeble infants, small quantities of wine may be administered. In regard to follicular enteritis, careful treatment with a wet nurse is essential, and quinia is a valuable adjuvant. When from any cause quinia cannot be taken by the mouth, it may advantageously be administered in the form of a clyster. Dr. Rapmund prefers the hydrochlorate of quinia, and its intense bitterness may be to some extent concealed by the addition of a little glycerin to the mixture. The flavour is also masked by its being dissolved in coffee.—*Practitioner*, Aug. 1874.

## Medicine.

### *Cases of Convulsion from Organic Brain Disease.*

Dr. W. R. Gowers reported (*British Med. Journal*, August 29, 1874), at the recent meeting of the British Medical Association, a series of cases in which the commencement of the fit was deliberate and local, and the cerebral lesion was obvious and circumscribed. The first case was that of a child with old renal disease, who died after a series of unilateral (left side) convulsions. Each fit began equally in the two frontal muscles; then passed to the orbiculares palpebrarum, but affected the left more than the right; and then involved the angle of the mouth, the arm, and the leg, on the left side only. A series of fits, probably similar, had occurred two months before. After death, an old hemorrhage was found in the white substance of the right hemisphere, just above the lateral ventricle, involving, by its adjacent softening, a small portion of the gyrus fornicatus. The author pointed out that Dr. Broadbent's hypothesis, which explains the escape of the bilaterally acting muscles of both sides in hemiplegia, equally explains their involvement in a convulsion due to a lesion in one cerebral hemisphere. The second case was that of a man suffering from phthisis, who died after a series of convulsions beginning unilaterally by a special movement of the left hand and arm, and spreading thence to the side of the face and leg of the same side, and subsequently to the corresponding parts of the opposite side. After death, there was found an area of extreme congestion of the convolutions of the right frontal lobe, extending across the anterior half of that lobe from the longitudinal fissure to the short anterior limb of the fissure of Sylvius. The congestion was due to the extension of a thrombus from the superior longitudinal sinus into the vein from this part of the frontal lobe. The case derived its chief interest from a comparison with the results of experiments on animals. The affected area was anterior to Dr. Ferrier's centre for the movements of the hand in monkeys. The third case was that of a girl who had suffered for six years from convulsions with loss of consciousness, all the fits being preceded by an aura in the left wrist. By blistering above the left wrist, the aura had been for a time transferred to the opposite side. After death, a small tumour was found in the white substance of the left hemisphere. It contained two calcareous masses, and was evidently of considerable duration. If the cause of the convulsive attacks, and none other, were discoverable, it could only have produced an aura, and probably, therefore, commencing convulsion in the arm of the same side, by acting on the opposite hemisphere of the brain by means of the commissural fibres of the corpus callosum in which it was placed.

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### *On Paralysis and Cutaneous Disease.*

*L'Union Médicale* for June 30, 1874, contains the following case by M. Lancereaux. A woman, aged thirty-seven, keeper of a wineshop, had her cellars emptied during the insurrection of the Commune. After a month of great mental depression from this cause, she was suddenly attacked by left hemiplegia, without loss of conciousness, followed by aphasia. In six months she had recovered her speech, and in two or three more the paralysis had almost disappeared. From this time, however, her sight became weak, she felt severe pains in the loins, and afterwards in both legs, and a cutaneous eruption appeared on the feet. Nearly two years after the apoplectic attack she came under M. Lancereaux's care. There were then alopecia, left ptosis, with dilated pupil, and external strabismus. There was no palsy of the portio dura, and little or no remains of hemiplegia, but weakness of all the limbs. Sensation was perfect everywhere. She had severe stabbing pains in both legs. There was a scaly eruption with yellow crusts over the soles and backs of both feet, with slight redness and desquamation up the legs. While she was under observation large bullæ formed on one foot, and there was so much inflammation around it that it resembled erysipelas; the inguinal glands became also

enlarged and painful. Two months later a chronic slightly scaly eruption appeared first on one and then on the other hand, occupying the palms and wrist, and looking like syphilitic psoriasis. Meanwhile the patient kept her appetite, and the urine, pulse, etc , continued normal. The toe-nails became longer, thicker, and more distorted, the feet became completely covered with small white scales, with occasional bullæ, and on removing these the skin was found red, smooth, and tense, as if it had been burnt. The toes gradually atrophied, and the lymphatics could be felt as hard cords up to the inguinal glands. The affection of the hands also spread up to the elbows. About eighteen months after her first attack, the patient was seized with spasms of the neck and limbs, became unconscious, and died in twelve hours. The organs of the thorax and abdomen were found to be healthy; but for some unexplained reason the brain and cord were not examined. M. Lancereaux inferred that all the phenomena were due to some chronic disease of the nervous centres, affecting the nutrition of the skin by trophic nerves. [The unfortunate omission makes this remarkable case of less value than it should have been. Dr. Pye-Smith has seen at least three cases which he believes to correspond to that of M. Lancereaux. They were all in women, and began with coldness and numbness of the fingers, followed by redness and desquamation with anæsthesia and atrophy. In the earlier stage the appearance was like that of a chilblain, afterwards more like chronic eczema squamosum, and finally, in one of the cases, a patient of Mr. Cooper Forster's, at Guy's Hospital, more than one of the phalanges shrivelled and fell off. In this case there was a similar slow atrophy and dry gangrene of the toes. In none of these patients were there any symptoms of disease of the nervous centres, and it may well be that the cutaneous affection described by M. Lancereaux, as well as the hemiplegia, may have been both due to disease of the arterial system rather than to any primary lesion of the brain.]—*London Med. Record*, Aug. 15, 1874.

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*On the Functions of Brain and Muscle considered in Relation to Epilepsy.*

Dr. J. Thompson Dickson (*Journal of Mental Science*, October, 1873) discusses some of the recent opinions as to the nature of epilepsy, and in particular those of Dr. Hughlings Jackson, who regards the epileptic phenomenon as the result of a "discharge" from a damaged portion of the brain, which he speaks of as a "discharging lesion."

Dr. Dickson's own views have been already stated in the *British Medical Journal*, November, 1867, in the *Journal of Mental Science*, July, 1869, and in the *British Medical Journal*, June, 1870, and he is of opinion that: 1. Epilepsy is a contraction of the cerebral capillaries and small arteries, the order of its stages in epileptic attacks being, first, irritation of the brain, either direct or secondary to exhaustion; secondly, contraction of cerebral capillaries and small arteries; thirdly, cerebral anæmia, and consequent loss of consciousness; 2. The muscular contraction and spasm, with all the phenomena of epilepsy, are secondary, and not essential or constant, but are all manifestations of imperfect nervous control, or a loss of balance between the nervous and other systems.

On certain points pathologists are agreed. We know with certainty that the seat of the lesion or lesions is the surface of the brain. The views of Drs. Bright, Wilks, and H. Jackson on this point are confirmed by Dr. Ferrier's well-known experiments of faradization applied to the cerebral surface. And that there is a condition of anæmia and contraction of the vessels at the time of the seizure, is proved by the experiments of Kussmaul and Tenner, by Dr. Dickson's own, and by observation of the pallor associated with the invasion of epilepsy.

Dr. Dickson disputes Dr. Jackson's theory that the normal function of nerve-tissue is to store up and expend force, which theory, he says, involves the notion that the nerve-force behaves as static electricity, and is capable of being accumulated in the cells of the gray matter, as the electricity is accumulated and discharged from a plate or jar, which he thinks not only improbable,

but impossible. "That the nerve-cells are capable of storing up motion in some mode or modes, is only in a very limited sense true; the principal modal changes which go on in the brain are chemical." The function of muscle is contraction and movement, and, when muscles are perfectly normal, they will, if liberated from control, perform their function spontaneously, and will continue to perform it until their potential energy is exhausted. The new-born infant, and the new-born cow or horse, move, not from mandates sent to their muscles from their untutored brains, but from spontaneity, from the tendency of the healthy muscles to perform their function. The seat of control over each muscle is the region or spot in the gray matter of the brain wherein its first motions were recorded, and which thenceforth was destined to become the controlling centre of its motion. That we may have loss of function of any organic tissue is perfectly true, but that we ever have over-function does not seem to be strictly physiological, or possible; that a tissue like the brain should "store up more force than in health," seems almost impossible. The function of the brain may be interfered with, and become irregular or cease; and as the healthy brain's function is not to give out discharges, but to maintain control, so the badly nourished brain, or the atrophied brain, loses its power of maintaining control, and the function becomes imperfect or irregular, and under some circumstances, altogether ceases. A fact which is distinct and clear is, that the seat of the expenditure of force in any movement is in the muscles, and not in the brain. A fact recorded by Galvani, and verified by Niobi, is that the set of the current in the nerves during muscular contraction is not in a direction from the brain to the muscle, but from the muscle to the brain. It requires no direct nervous stimulus from the brain to cause muscles to contract. Healthy and well-nourished muscles will contract, as is their wonted function when the brain is removed altogether, as in the decapitated. We may, therefore, from the evidence we have, conclude that the muscular contraction and spasm in epilepsy is the necessary consequence of a loss of cerebral control. If the damage be in one convolution only, we may have a local muscular contraction; if the lesion be in more than one, we may have contractions in several regions, or the whole brain may become anæmic, and the convulsions general.

Epilepsy, then, is not a display of sudden and ruthless expenditure of stored-up force, but is the manifestation of a condition of weakness and exhaustion, the primary seat of which is the surface of the brain. The exhibition of strength, we further see, is the loss of the potential energy of muscle, which it is the function of the nervous system to control and guard; and in the muscular exhaustion is to be sought the cause of the temporary paralysis which often succeeds epilepsy.—*London Med. Record*, April, 1874.

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### *On Epileptic Sweat.*

Dr. H. Emminghaus (*Archiv für Psychiatrie*, 1874) recently met with two cases which confirm some of Griesinger's remarks on epilepsy. In both of them epileptic conditions were present, and in both paroxysms of sweating, which in the woman were accompanied by feelings of giddiness, though this combination did not invariably occur in the man. In the woman there had been attacks in childhood, sweating with fainting at the climacteric period, and she had the peculiar epileptic expression, contraction at the corners of the mouth, form of skull, etc. In the other case there had been no true fits, only indefinite signs of them, but there was strong hereditary predisposition, and he indulged in spirituous liquors. Griesinger's remark was that "sudden outbreaks of sweat often are connected with epileptic nisus," and that all sorts of symptoms such as cold in the feet, sudden blushing, gastralgia, giddiness, should be borne in mind as connected with epilepsy, for then alone they get their true interpretation. The woman's case showed a fact noted by Griesinger, that often an epilepsy which appears in childhood disappears afterwards, and then returns after periods of ten years; she had been free from the fits since puberty, and the sweating began when she was fifty. In his book on diseases of children, Emminghaus relates the case of a boy affected with mitral disease, and whose

sister had *petit mal*, in whom, besides constitutional weakness there were muscular spasms and loss of consciousness when voluntary muscular efforts, such as running, were made. Many persons ascribe the sweating of epileptics to the excessive muscular action; but this is not always the case, for in the instances above noted the eruption of sweat was directly connected with the vaso-motor affection of the complaint.—*London Med. Record*, July 8, 1874.

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### *Parotiditis as a Sequence of Acute Disease.*

Professor Crocq, of the University of Brussels, has recently read an interesting paper at the Brussels Royal Medical Society (published in their *Journal de Médecine* for January), having for its title "Parotiditis Consecutive to Severe Acute Diseases."

He observes that this is one of the most serious and remarkable complications occurring in certain acute diseases, and especially in typhoid and typhus fevers, scarlatina, cholera, dysentery, measles, and smallpox. It is always to be regarded as a formidable phenomenon, and is met with at an advanced period of the affection during which it manifests itself. Thus in typhoid it occurs towards the third or fourth week, in scarlatina at the period of desquamation, and in cholera during the stage of reaction. The old writers admitted two forms of parotiditis, which they termed "critical" and "symptomatic," basing the distinction on the theoretical views of disease which then prevailed. A parotiditis was regarded as critical when it appeared towards the end of the disease, not only without impeding its resolution, but even favouring this by inducing a useful revulsive action, and diverting the peccant matter from the nobler internal organs to the salivary gland. When it appeared at an earlier period, and seemed only to add to the violence of the disease, it was termed symptomatic. The former was regarded of favourable, and the latter of unfavourable augury; but no proper character distinguished the one from the other. The view that then prevailed, that the cause of the parotiditis was the determination of the morbific principle to the parotid gland, is still admitted by some under the qualification of the term "metastasis," indicating, however, a purely hypothetical condition. It has also been sought to establish a more rational explanation by attributing the glandular affection to a pyæmic process; but this would only apply at most to a few of the cases. Even in certain cases of typhus and typhoid, which may seem to admit of this interpretation, the parotiditis coexists with no other alteration which can be attributed to pyæmia. It also is far from always going on to a state of suppuration, while this is rarely absent in lesions which are really pyæmic in their nature. Again, in true traumatic pyæmia we do not find any localization effected in the parotid gland, this being one of the organs in which the metastatic abscesses of that affection are most rarely met with.

Numerous observations enable Professor Crocq to establish what he believes to be a truer genesis of the phenomenon. Parotiditis is always accompanied by well-marked stomatitis, characterized by redness, turgescence, and hypersecretion of the mucous membrane of the mouth. This membrane is covered by deposits of various nature—mucous, epithelial, fuliginous, lining a more or less extended surface, especially the back of the tongue, and often also the gums, the teeth, the lips, and the inside of the cheeks. This stomatitis is well marked in typhoid and in exanthematic typhus, occurring especially at an advanced period of the disease, when it is aggravated by the action of the air on the buccal mucous membrane, as the patients generally lie with their mouths open. It is then also that the parotiditis is observed. The same conditions are observed to be present in the cases in which parotiditis supervenes during the stage of reaction in cholera; and in scarlatina and variola, stomatitis is one of their ordinary symptoms. In measles, too, the buccal membrane is often the seat of an eruption resembling that of the skin, and very appreciable, especially about the palate. When in the course of this parotiditis pressure is made on the parotid duct, a drop of pus is observed to issue from its orifice—a fact which M. Crocq has never found absent. It exists, indeed, from the very first

appearance of the complication, when the patient only complains of some pain in the parotid region, or some swelling is observed to exist there; and it is alike observable in the cases which terminate by resolution as in those which go on to suppuration—proving that this drop of pus does not proceed from suppuration of the gland, since it precedes and is independent of it. In fact, the stomatitis, having reached a certain degree of intensity, is propagated along the duct and its ramifications to the substance of the gland. In the same way the submaxillary gland may become affected, and a drop of pus be pressed out from the orifice of Wharton's duct. But this is quite exceptional, the stomatitis at the under surface of the tongue being generally absent or only slight.

This transmission of catarrhal inflammation to the excretory ducts and the glands themselves is no isolated occurrence, being met with in other parts of the body. Thus, the orchitis which succeeds to blenorrhagia is due to the propagation of the inflammation from the urethra by the vas deferens to the epididymis and the testis, this scarcely ever occurring before the fifth week, the epoch at which the irritation has reached the prostatic portion. This affection, exactly like parotiditis, was long regarded as being due to metastasis or to the action of peccant matter. In most cases, also, catarrh of the biliary ducts results from an extension of gastro-duodenal inflammation to the choledochus; and other inflammations may extend to the hepatic parenchyma itself and give rise to hepatitis—a fact M. Crocq has several times had the opportunity of observing.

Most authors have considered this inflammation of the parotid as originating in the cellular tissue surrounding it, and spreading thence to the glandular substance. Whenever M. Crocq, however, has had the opportunity of examination after death, he has always found the gland itself and its excretory duct the seat of inflammation. It is easy to explain how the error has arisen, as all the phenomena of inflammation—such as redness, exudation, and suppuration—are often much more marked in the interstitial cellular tissue, and they may even extend to the superficial cellular tissue, and there become predominant. This does not imply that the phenomena have originated there, but, as may easily be admitted, that they find there a soil better suited for their evolution. At all events, this is the point now insisted upon: the inflammation, proceeding by Steno's duct, necessarily and primarily invades the proper elements of the gland, which transmit it to the cellular tissue in which they are embedded.

These considerations lead to the prophylactic and curative treatment of parotiditis consecutive to acute disease. The buccal membrane must be kept carefully cleansed, and all desiccation prevented by means of emollient or slightly astringent applications. As soon as the first symptoms appear, whether these be pain or tumefaction, pressure must be exerted on the gland and its duct, so as to expel from the latter any irritating secretion which it may contain. At the same time leeches may be applied to the swelling, upon which should also be practised every three hours a mercurial friction, followed by a linseed-meal poultice. By these means resolution may often be obtained. —*Med. Times and Gaz.*, May 9, 1874.

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*On the Changes which certain Mechanical and Chemical Irritants produce in the Pulmonary Parenchyma.*

W. Koch (Langenbeck's *Archiv für Klinische Chirurgie*, vol. xv.) reports experiments conducted with all necessary precautions, in which the lungs of animals were subjected for a varying length of time to irritations produced either by the introduction of an acupuncture needle, or by the injection of solutions of iodine varying in strength from 1 in 120 to 1 in 20. The results have always been the same. The animals did not evince any signs of pain or of other general disturbance; only in a very few instances, in which the solution of iodine was very strong, the parenchymatous injection was followed by a short cough. There was no increase in temperature or in the frequency of respiration. On *post-mortem* examination, it was found that the irritated pulmonary parenchyma was converted into connective tissue.

The present experiments allow the conclusion that it is possible to convert pulmonary into connective tissue by means of parenchymatous injections of iodine, without producing constitutional disturbance of any kind.—*London Med. Record*, Feb. 4, 1874.

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*Connection of Inflammation of the Heart with Erysipelas of the Face.*

M. Jaccoud (*Gazette Hebdomadaire*, 1873, No. 23) has observed that in a large number of cases inflammation of the heart, as endocarditis, pericarditis, or myocarditis, is associated with erysipelas of the face, and is disposed to regard the connection between it as close as that which exists between cardiac affections and acute articular rheumatism. In the majority of instances he finds the mitral valve affected, and more rarely the tricuspid; but he has never found the semilunar valves implicated. As a rule the cardiac disease is only temporary, and leaves no permanent defect behind it. The systolic bruit is most audible at the apex of the heart, and makes its appearance during the attack of erysipelas or a few hours before the occurrence of the latter. The bruit does not bear any direct relation in its loudness to the amount of febrile disturbance present. There is no articular rheumatism, pleurisy, or pneumonia accompanying the attack.—*Practitioner*, Jan. 1874.

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*Contraction of both Auriculo-ventricular Orifices of the Heart.*

Dr. Hayden related to the Medical Society of the College of Physicians, Ireland (*Irish Hosp. Gaz.*, April 15, 1874), a case of this rare form of cardiac disease, in which he had made the diagnosis during the patient's life. Up to the present time, Dr. Hayden said, there were only eight cases of this form of disease recorded in the Transactions of the London and Dublin Pathological Societies. Three specimens had been exhibited at the Pathological Society of London, but the diagnosis was not made in any instance. In the Pathological Society of Dublin, five examples have been shown; the first by Dr. Stokes in 1862; the second by Dr. James Little in 1867; the third by Dr. Cryan in 1870; the fourth by himself in 1871; and the fifth by Dr. Cryan again in 1872. An advancing step towards our knowledge of this condition had been obtained by these cases, but no positive diagnosis was made in any of them. It was remarkable that only two out of the entire number of eight cases recorded, as above stated, were in males; and that all the cases, with two exceptions, occurred between the ages of 20 and 30. Case.—A female, aged 25, was admitted under Dr. Hayden's care, into the Mater Misericordiæ Hospital, on the 11th of March last. She had had measles when 16 years of age; had caught cold during convalescence, and had never been well since. Five years ago she spat blood, and subsequently had done so repeatedly. Menstruation stopped last Christmas, and her feet swelled three weeks before admission. There were general venous congestion, great œdema of lower extremities, depression of temperature, orthopnœa, constant dry cough, exceedingly rapid and feeble pulse, with evidences of pulmonary œdema and peritoneal effusion. The apex of the heart pulsated in the fifth intercostal space; there was no fremitus. At the apex a presystolic murmur was audible at the left side of the sternum; in the fourth intercostal space a second murmur, of the same rhythm as the apex-murmur, but harsher, and extending further back into the long pause, was also heard. Between the sites of these two murmurs neither was distinctly audible. Upon this latter fact alone Dr. Hayden ventured to diagnose the double lesion, assigning, however, due weight to the difference in harshness and length of the murmurs. The patient died three days after admittance, the feet and legs having become previously gangrenous. *Post-mortem* examination.—Fluid in pericardium. Heart weighed eleven ounces, and was of a globular figure. The tricuspid orifice was greatly contracted; the right ventricle itself was not dilated and thickened, and the endocardium opaque. The mitral orifice was still more contracted than the tricuspid, and was of a button-hole shape. The left ventricle was not dilated; its apex was remark-

ably thinned. Dr. Hayden said that from the knowledge he had gained from his former case he was enabled in the present instance to make the diagnosis. The facts upon which that diagnosis rested were: (1) The existence of two centres of murmur, one in the usual position of the apex, and the other corresponding to the junction of the fifth left costal cartilage with the sternum; and (2) That around these two points, respectively, the murmur faded off; and that between the areas of the murmurs there was a space in which neither murmur was distinctly audible. The fact of the right murmur being harsher and more prolonged than the left was due, in Dr. Hayden's opinion, to an entanglement of fibrin in the tricuspid orifice. The extreme venous congestion attending this form of cardiac disease, would alone warrant the suspicion of the twofold lesion. In all the reported cases there was an absence of intensification or reduplication of the second sound, which Dr. Hayden attributed to both ventricles being in the same condition. In reply to a remark from Dr. MacSwiney, Dr. Hayden observed that the area of diffusion of the right murmur fell short not only of the right side, but even of the mesian line of the sternum; and that he thought it a mistake to suppose that tricuspid murmurs are generally audible to the right of the sternum.

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*Case of Arterio-venous Aneurism of the Arch of the Aorta, the Cavity of which communicated with the left Brachio-cephalic Vein.*

M. Chaboud reports (*Lyon Médical*, Dec. 21, 1873) the following case: S., æt. 56, came under Dr. Laure's care in November 1872. No special hereditary predisposition; good general health and vigorous constitution. Up to May 1872 his general health was excellent; no cough nor oppression of breathing. One morning patient awoke with a severe pain in the left shoulder, which next day extended to the arm, and disappeared on the following day, when the patient, looking in the glass, noticed that the left side of his neck and the lower half of the face were swollen, and little by little the swelling extended to the shoulder and affected the arm. This, however, disappeared entirely in fifteen days. A week later, the jaw, neck, shoulders, and arm again became enlarged, as also the left half of the thorax, before and behind. A little oppression resulted, but no pain. This œdema came and went, but always its disappearance became less perfect. In August the patient noticed that the veins of the left side were swollen, and the skin assumed a violet tint, while oppression of breathing became more severe. In September the symptoms increased, and the arm and hand became swollen. One day in October the patient, putting his hand on the swelling in the neck, noticed, for the first time, a sensation like the purring of a cat. No treatment had been adopted. He entered hospital in November. The cheek, left half of neck, shoulder, and arm, were œdematous, and the chest of the same side, as far down as nipple. The forearm was covered by an eruption like acne; the skin was livid. The lesser veins under the skin were prominent and well marked. The large veins of neck and chest were twisted, swollen, and varicose. In some parts they formed plexuses of dark-blue colour, projecting like tumours. Two, especially, one over each sterno-clavicular articulation, were soft and reducible on pressure. The hand felt a considerable thrill in these tumours, especially in the left one. They were united by a large vein. In the regions both above and below the clavicle, the purring thrill was still more intense on pressure. Percussion signs were rendered doubtful by the œdema of the chest. A systolic *bruit de souffle* was extremely loud. The murmur was prolonged even to the second sound. It was strongest over the base. Sounds were clear, and with no murmur at the apex. Over the varicose tumours the murmur was continuous, but strengthened at the systole. Many other symptoms are detailed with much minuteness; the chief are: Weak pulse in *right* arm; dulness of chest on left side, both before and behind, with other evidences of condensation of lungs; slight expectoration, no cough, good appetite and digestion; habitual constipation; face pale, with livid lips; no weakness nor emaciation; no pain, but only oppression of breathing, brought on by walking or standing, or even lying on his back or on his right

side. The diagnosis of "an aneurism of the arch of the aorta, communicating with the left innominate vein," was made. Iodide of potassium and digitalis were given. During the next three months the swelling and difficulty of breathing rapidly increased, with loss of speech and weakness, and he died on 22d January.

*Post-mortem.*—Condensed and atrophied lungs, with pleuritic effusion. Heart was hypertrophied and atheromatous. About an inch and a half from the region of the aorta a tumour, as large as a small orange, was present. From this opened the innominate artery and the left innominate vein. The vena cava superior was to the right of the tumour, and had no communication with it, nor with the left innominate vein. This was not merely from the presence of a clot, but the coats of the vessels were perfectly united.—*Edin. Med. and Surg. Journal*, March, 1874.

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*Ailanthus Glandulosa as a Remedy for Dysentery.*

In a recent issue of the *Archives de Médecine Navale* is published an official note, addressed by Dr. Robert, who is the medical chief of the naval division of China and Japan, to the inspector-general of the health service in the French navy, calling attention to a drug used by Chinese physicians in the treatment of dysentery. It consists of the root bark of the *Ailanthus glandulosa*, Desf., a plant belonging to the natural order Simarubaceæ, very common in the north of China and less so in Japan. It is also frequently cultivated in France and Italy for the purpose of shade, whilst its leaves have been used as food for silkworms.

The bark of the root is the only part employed. It is white when fresh, resembling mallow root, but it acquires a grayish tint in drying. It is fibrous and loose in texture, and is almost without smell. An infusion of this bark, however, exhales a slightly nauseous odour, and possesses an excessive bitterness resembling that of sulphate of quinia. The Chinese physicians employ the root in the fresh state only; but Dr. Robert, having been compelled to use some that had become dry, found no sensible difference in its action in the two states.

For administration, fifty grammes weight of the fresh root is cut into very small pieces and triturated with seventy-five grammes of hot water for a few minutes in a mortar, in order to soften the bark, and then strained. A teaspoonful of this strong infusion is administered as a dose morning and evening, alone or in a cup of tea. Taken in this form, it provokes vomiting. The medicine is administered in this manner during three days, the patient being kept upon full diet. After that time the ailanthus is omitted and the diet is altered to broths until health is restored. If after eight days' treatment the patient is not cured, the Chinese physicians recommence the use of the ailanthus; but Dr. Robert states that he has not met with a single case in which this resumption has been necessary, although he has had under his notice some where the disease has lasted several months, as well as others of more recent origin.

The principal symptoms which follow the administration of the ailanthus are said to be nausea, and sometimes vomiting, followed by a temporary lowering of the pulse. The disappearance of blood from the evacuations commences on the first day, and is complete on the second; the colic ceases a little later. The effect of the drug upon the colour of the evacuations is variable. Dr. Robert sums up by expressing his opinion that the administration of the *Ailanthus glandulosa*, as witnessed by him in China and Japan, gave superior results to that of ipecacuanha, astringents, alone or combined with opiates, or calomel. The remedy, he says, is only known to a portion of the Chinese physicians, a circumstance which he attributes to their custom of preserving the secrets of their practice.—*Amer. Journ. of Pharm.*, June, 1874, from *Pharm. Journ.* (London), May 9, 1874.

### *On the Therapeutics of Gall-Stone Colic.*

The *Allgemeine Wiener Med. Zeitung*, of November 18, 1873, contains a short article on this subject, by Dr. W. Pichler, who is one of the medical men attached to the Carlsbad baths. He remarks that gall-stones are matters of daily occurrence in Carlsbad practice—at least in large practices. On this account the local doctors have a larger experience of these concretions than any other medical men. The severity of the pains is well known, and women often say that they are far worse than those of childbirth. On account of this severe character, and from the fact that all sorts of reflex phenomena, vomiting, severe rigors, epileptiform and other convulsions, and the like, are frequently associated, it may easily be understood that next to the application of warmth, in the form of cataplasms and baths, narcotics must play a leading part in the treatment; opiates, morphia by the mouth or rectum, and subcutaneously injected, and chloral-hydrate being all employed by turns. Success in the employment of narcotics for this object, depends very much on the skill of the prescriber—and he very seldom complains that there are too many medicines of this class. Nor is the mode of application indifferent. The result of much experience of some of the most painful cases is, that the best results are obtained from hydrate of chloral, combined with the internal or subcutaneous use of the salts of morphia. For it often happens that moderate doses of these preparations of morphia are of no use against the severity of the pains, and we may, from special reasons, be disinclined to have resort to larger and more dangerous doses. In such cases let a dose of chloral hydrate be administered, and we shall soon be gratified with the result. Trials of each separately, and of the two in combination, have convinced him of the superiority of the combination to the use of either alone. After Dr. Pichler had found this experimentally, he learned that others had made a similar discovery. For example, Nussbaum found that a patient, who had by mistake received a subcutaneous injection of acetate of morphia before being chloroformed, slept for twelve hours after the operation, and was during this sleep insensible to all kinds of painful impressions. Claude Bernard found that chloroform narcosis lasts much longer in animals to whom opiates have been given beforehand. Goujon and Labbé, from repeated experiments, announce that the combination of small doses of morphia with chloroform produces several hours' complete insensibility to pain, although there may be no sleep. Another French observer, Rabuteau, has made this experiment. He gave five centigrammes (=0.77 grain) of narcein to a dog, and then chloroformed him. After waking from the narcosis, the dog was quite insensible to pain, although he went round the room, and recognized his master. There was complete anæsthesia; he could be pinched, pricked, or have his toes trod on without any sign of feeling, and although full grown, sensation did not return till the next day. The combination of chloral hydrate and morphia offers similar advantages to the practical physician, and Dr. Pichler recommends it most strongly in gall-stone colic, in the passage of renal calculi, and in neuralgia.—*London Med. Record*, Jan. 21, 1874.

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### *Granular Contracted Kidney in a Child Six Years of Age.*

Dr. Barlow read a paper before the Manchester Medical Society (*Brit. Med. Journ.*, April 11, 1874) on the case of a child, aged, at death, five years and eleven months, whose first symptoms, noticed two years before death, were frequent micturition and the passage of a large quantity of urine (between three and four pints in the twenty-four hours). The prominent symptoms were peculiar brownish cachectic appearance of the skin, anomalous dyspeptic symptoms, deafness, etc. No albumen was found in the urine in the early stage (twelve months before death), but shortly before death the quantity of urine passed diminished to one pint in the twenty-four hours, and the amount of albumen was large. There was no œdema at all, and the child died in uræmic convulsions, without a trace of dropsy. On *post-mortem* examination, the lungs were found to be emphysematous, the heart hypertrophied, the spleen small,

hard, and firm, with evident thickening of the fibrous capsule. The liver was apparently normal. The kidneys were small, contracted, and granular, the right much smaller than the left, and in the larger were found one or two small cysts of the size of a hemp-seed. The microscopic appearances showed almost total disappearance of true glandular structure; and the replacement by fibroid substance, and the contrast between this and sections of a healthy child's kidney, were shown to the meeting. The fibrous stroma of the liver was also found to be increased, when examined microscopically and compared with a healthy child's liver. The spleen showed increase of its fibrous stroma. Dr. Barlow believed the case to be unique in point of age. The nearest in that point was the case of a child, aged 9, mentioned by Sir W. Gull and Dr. Sutton.

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*Treatment of Lupus Erythematosus.*

Dr. Theodore Veiel, in an inaugural dissertation (Tübingen, 1872), gives a record of all the cases of lupus erythematosus which have been treated at the institution of his father and brother at Canstatt during the past seventeen years, with a good description of its natural history, and a detailed account of the various forms of treatment employed against it. Up to the time of its publication, the best results were obtained by chloride of zinc in solution in an equal quantity of alcohol, used as follows: A blistering plaster is first applied to the whole affected part. The epidermal covering, which forms a thick and opaque coat, is then removed, revealing the deep-red velvety papillæ, sharply defined by contrast with the firmer and paler healthy portions. The diseased parts are then painted with the solution. The pain is considerable. The yellowish-white varnish-like crust which forms is removed by poultices on the third or fourth day, and the cauterized parts are found covered with epidermis, offering in this respect a marked contrast to lupus vulgaris, which exhibits, under similar treatment, a surface of exuberant granulations, which cicatrizes much more slowly. Points which still remain open quickly heal under the use of the alcoholic solution of chloride of zinc, diluted one-third with water. Cauterization in this way is repeated until the cure is complete. Although the scars are larger than after spontaneous cicatrization, they are not in the majority of cases disfiguring.

In an article on the treatment of lupus and lupus erythematosus (*Archiv für Dermatologie and Syphilis*, vol. v. part 2, and *Boston Medical and Surgical Journal*), Dr. Earnest Veiel gives a detailed account of the later method employed at the Cannstatt Skin Hospital, which is a combination of the chloride of zinc cauterization above described, and Volkmann's method of scarification. For this purpose, and to prevent the great loss of blood which often follows the use of the customary single lancet, 150 to 200 grammes generally flowing when the operation is prolonged for the necessary half-hour, in ordinary cases affecting the face, he has designed a set of blades placed side by side, and inserted in a common handle, by which six punctures are made simultaneously. The duration of the operation is reduced to five or ten minutes, and thus more immediate attention may be given to controlling, by pressure, the hemorrhage. On this account, too, the necessity for the use of anæsthetics during the operation is diminished; although, as the author says, the principal effect upon the patient is not produced by the scarification and cauterization, but by the persistent pain which often lasts eighteen or twenty-four hours, and then "the danger which is a part of every administration of chloroform is out of all proportion to the amount of pain to be endured."

Directly after the puncturing, the parts are cauterized with the alcoholic solution of chloride of zinc. Superficial suppuration follows, and crusts form, which fall off in from six to ten days, after which the puncturing and scarification are again performed. This is repeated until a smooth and uniform cicatrix is formed, which subsequently becomes white. Generally, five to eight times are sufficient for a perfect cure. Relapses, however, are not wanting, even with this treatment, manifesting themselves as red points in the cicatrix, which by confluence are converted into true lupus spots; but these are easily nipped in the bud by a repetition of the treatment.

In ordinary lupus, Dr. Veiel thinks this method effects a material reduction in the time of cure. A longer period, however, between the operations is required, inasmuch as ulceration often occurs in the parts most deeply cauterized, which must be healed by repeated applications of the diluted solution of chloride of zinc before another scarification.—*London Med. Record*, Jan. 28, 1874.

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*On Alopecia.*

In an article on alopecia published in the *Thèses de Paris*, 1874, No. 76, Dr. Courrèges states that he has demonstrated that the fungus of the *Alopecia areata*—the *Microsporon Audouinii*—is not situated, according to the statements of Gruby and Bazin, in the hair, nor even around it, but in the most superficial portions of the horny layer of the epidermis. M. Malassez has made this cryptogam a subject of special study, and presented a note regarding it to the Société de Biologie on December 27, 1873. The fall of the hair would not be due to a cryptogamic change in it, but to a vice in nutrition, induced by the presence of the vegetable parasite in the superficial parts of the epidermis. M. Courrèges therefore admits, like Gruby, Bazin, and Luiller, that alopecia is of a parasitic nature, but in an indirect manner. He rejects Hebra's theory, which makes alopecia depend on a disturbance of the organs of nutrition.

Alopecia achromatosa and alopecia decalvans would therefore be only two forms of the same disease. With regard to treatment, M. Courrèges prefers shaving to epilation, which is in conformity with M. Malassez's latest researches. The head should be shaved at least once a week, or even twice, and then washed with a solution of hydrochlorate of ammonia and corrosive sublimate, each one gramme, in 500 grammes of water. Sometimes M. Courrèges substitutes an ointment of 1 gramme of sulphate of mercury to 30 grammes of lard.—*London Med. Record*, July 1, 1874.

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*Hereditary Local Hyperidrosis.*

M. Ollivier, of Paris, has recently recorded a case of the above affection, which, as far as he knows, has never been described before. Local hyperidroses are, of course, not so very rare, but it is their hereditary transmission which is here remarkable.

The patient is a man, aged 21 years, quite healthy, but afflicted since birth with constant sweating of that part of the skin of the face which is innervated by the right superior maxillary branch of the fifth nerve—namely, the lower eyelid, right half of the nose, the cheek, and upper lip of the right side. On the bridge of the nose the sweating extends a little beyond the median line towards the left, evidently from the interlacing of the terminal filaments of the contiguous nerves of the two sides. Even in extremely cold weather the affected half of the face is always moist, and this moisture may become intensified into a copious sweat, which runs down the face in streams. Its reaction is acid. Warmth, alcohol, exercise, and mental emotions (especially the last) cause the greatest flow of perspiration. If he takes part in an animated discussion, he is obliged to keep his handkerchief always applied to his cheek. The skin becomes injected when the sweating is most active; but in all other respects there is not the slightest perceptible difference between the right and left cheeks.

The patient's maternal grandfather had an exactly similar affection all his life; he died at the age of eighty-two. His aunt (mother's sister) and her only daughter also suffer, while her two sons are free from it. In all these cases the same nerve-district and the same side of the face are affected, and in none of them can any cause, direct or indirect, be discovered to account for it.—*Med. Times and Gaz.*, June 6, 1874.

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*Morbid Sweating of the Feet and its Treatment.*

Dr. Debrousse Latour has lately published a thesis on local sweating, in which the unpublished observations of M. Ollivier, of the Paris Faculty of Medicine, are incorporated with those of the author.

The forms of local sweating which offer the greatest number of interesting points are, according to Hebra, those which affect the armpits, the genital organs, the palm of the hand, and the sole of the foot. For the present, M. Debrousse Latour confines his remarks to the last-mentioned affection, which elevation of the temperature for the time being raises into a really insupportable condition of disordered function. The causes of this morbid perspiration are little known; it is not an attribute of the lymphatic temperament, nor always of a want of cleanliness; it is not contagious, nor does anything prove it to be hereditary. Its symptoms are well known, as well as the disagreeable accidents to which it gives rise.

The question arises whether it is prudent to accede to the wish of the patients who desire to be relieved from the annoyance of this affection. Without following the author through all his arguments, it will suffice to say that he agrees with almost the whole of the French medical profession in the belief that it is dangerous to suppress habitual sweating of the feet. "Perhaps, however," remarks Debrousse Latour, "we must here draw a distinction between patients having a good constitution and those predisposed to pulmonary pthisis or phlegmasiæ of the respiratory organs." In support of this judicious reservation, the writer cites the following fact, observed by M. Ollivier in the case of a medical student whom he treated.

M. X., aged twenty-one, had been troubled during two years with partial sweatings of the feet, of an extremely disagreeable character. In other respects he was in good health, and there was nothing abnormal in the action of the organic functions; the appetite was good, and thirst moderate. The local sweating was so profuse as to oblige the sufferer to change his socks several times in the course of the day, and it exhaled a fetid odour, although it was clearly of a watery nature. The skin of the feet was whitish, and, as it were, macerated. M. Ollivier, nevertheless, found no indication against treatment for partial hyperidrosis. He prescribed foot-baths with Barèges water, a preparation of iron, and cold douches. In two months the malady had disappeared, and the cure afterwards continued without any change in the health of the patient. The hygienic treatment of this morbid state in delicate patients consists in avoiding sudden cooling of the feet. The patient should wear stout shoes or boots and woollen stockings, which should be changed frequently. If, in consequence of chill, sudden suppression of perspiration be followed by any unpleasant consequences, the sudoric hypersecretion should be brought on again by the use of very hot foot-baths, and afterwards by wearing woollen socks covered with oiled silk, or even stockings sprinkled with chlorhydrate of ammonia mixed with quicklime, in the proportion of two parts of the latter to one of the former. As a means of diminishing the disagreeableness of excessive and fetid perspiration, the following disinfectants may be used with advantage; the solution of permanganate of potash (0.05 centigramme of permanganate of potash to 250 grammes of water), or the solution of tincture of coal-tar (1 gramme tincture of coal-tar to 250 grammes of water). If the epidermis become softened by maceration, if it fall off, leaving the *rete Malpighii* exposed, and thus render walking difficult and painful, Hebra unhesitatingly recommends that the soles of the feet and the toes should be coated with a mixture of equal proportions of compound diachylon plaster and linseed oil, which should be melted before it is used; the excoriated portions should afterwards be covered with linen. So much as regards palliative treatment; but if the good constitution of the patient give warrant for more active measures, then lighter boots and thread stockings should be ordered, together with lycopodium, charcoal and tannin powders.

M. Gaffard, of Aurillac, recommends allowing some drops of the following liquid to penetrate between the toes:—

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|---|---|
| Red oxide of lead . . . . . | 1 gramme. |
| Subacetate of liquor plumbi . . . | 29 grammes. |

We have already seen how M. Ollivier succeeded in effectively combating sweating of the feet with Barèges water and cold douches. Lotions with aromatic vinegar will also be found useful. Another means consists in spreading

frequently in thin layers on the secreting parts clay softened in water and passed through a sieve. As to medicines given internally, and praised as specifics against general sweatings, such as the *Polyporus officinalis*, and the acetate of lead, MM. Ollivier and Debrousse Latour have arrived at the conviction that they are powerless against perspiration of the feet and other local sweatings.—*London Medical Record*, March 18, 1874.

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*Acne and other Affections of the Skin due to Bromide of Potassium.*

Dr. Theodore Veiel, of Cannstadt, contributes a very interesting paper on the above subject to the *Vierteljahreschrift für Dermatologie und Syphilis*, 1874, Erstes Heft. After referring to the literature of the eruptions produced by bromide of potassium, and giving the details of several accurately observed cases of his own among a number examinined in a large epileptical hospital at Stetten, he gives a summary of all the facts known about the disease at the present time.

In the first place, it is impossible to foretell what dose of bromide will give rise to an acne. Its early or late appearance seems to depend entirely on the constitution of the individual. Some persons get it with small doses, some only with large, while with others even the largest doses fail to produce it. The two sexes seem to be about equally predisposed to it, and the same may be said of constitution. Dr. Veiel has observed his form of acne as frequently in robust and florid as in delicate and anæmic persons. He has not been able to decide the question whether it resembles acne vulgaris in attacking principally young persons, as he has not had the opportunity of examining patients in middle life and old age who were taking bromide; and this point seems to have been passed over by others.

A greasy condition of the skin from abundant secretion of sebum appears to favour its occurrence; and if there are comedones, or acne vulgaris, present before the use of the bromide, they become increased by its action; but Veiel has never seen an ordinary acne disappear in a person taking it, as Dr. T. Fox and Dr. Cholmeley have (*Medical Times and Gazette*, Dec. 11, 1869). The efflorescences make their appearance gradually, and not in an acute form, with fever.

The locality selected is more extensive than in acne vulgaris, and there is a decided preference for parts where hairs abound. Thus, besides the face, chest, and shoulders, it attacks the hairy scalp, the eyebrows, and the hairy parts of the thighs and legs. It may even occur over the whole body. It thus resembles tar and iodine acne in its distribution. The colour is not at all characteristic. All gradations of tint, from rose colour to the deepest bluish and brownish-red, have been observed, and a coppery shade is not at all the commonest.

The development of the eruption, and the form of its constituent elements, exactly resembles that of acne vulgaris. Veiel was unable to find a trace of bromine in the contents of some of the pustules in two cases, while it was present in the urine. Although, therefore, he does not deny the possibility of its excretion through the sebaceous follicles, yet he considers that the quantity excreted, since it cannot be detected by chemical examination, is too small to set up inflammation in the follicle, and so give rise to the acne by direct irritation.

The only characteristic feature of acne due to bromide of potassium is its increase and diminution when the dose of the latter is raised or lessened. Bromide acne is distinguished from acne vulgaris by its predilection for the more hairy parts of the body, so that most of the pustules are pierced by a hair. It also occurs without the antecedent existence of comedones. Bromide acne thus resembles tar and iodine acne, but it can be distinguished from them by the chemical examination of the urine, as well as by a characteristic fetor of the breath, which affects all patients with acne due to bromide of potassium. This salt also produces some rather curious affections of the skin apart fr[om] which are deserving of especial attention from their diagnostic im[portance].

Thus, Veiel has met with several cases of an eruption on the legs exactly resembling erythema nodosum, which persisted as long as the bromide was continued, and quickly vanished on its being left off.

Another and more frequent eruption consists of a diffuse erythema, always absolutely limited to the lower extremities, and accompanied with fever and a great deal of pain. Dr. Haberle, Superintendent of the Epileptic Hospital at Cannstadt, observed the occurrence of foul ulcerations on the legs of two boys who were taking the bromide. Wheal-like elevations, from the size of a shilling to a florin, appeared on an erythematous base, and were exceedingly tender on pressure. They then assumed a warty aspect, and at last ulcerated. The ulcers showed no sign of healing as long as the bromide was continued, but healed spontaneously when it was omitted, leaving a pigmented scar.

The most interesting phenomenon which Dr. Veiel records in connection with bromide of potassium is the appearance of numerous large warts on the face (cheeks, nose, and eyebrows) and on the legs of a boy of sixteen, soon after he commenced taking it. The warts exactly resembled those which young people get on the backs of their hands. The largest was two centimetres high and a centimetre broad. Veiel believes that a development of warts under similar circumstances has not been before observed.

In conclusion, he points out that there is no direct relation to be traced between the appearance of the skin eruptions and the cessation or less frequent return of the epileptic fits. The beneficial action of the bromide may occur without any eruption whatever.—*Med. Times and Gaz.*, Aug. 8, 1874.

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*On the Treatment of Tetanus Neonatorum with Chloral-hydrate.*

Dr. A. von Huttenbrenner (*Jahrbuch für Kinderheilkunde*, vol. vii. p. 30), from observations made by himself and others, has come to the following conclusions. Tetanus of the newly born is not an absolutely mortal disease. It is accompanied by fever or not. Those cases which are very febrile and acute are probably dependent upon a general blood-poisoning, and the fever-free cases are to be looked upon as reflex spasm consequent upon peripheral excitation. The prognosis is more favourable in the non-febrile than in the febrile cases, although even in the latter recovery may occur. Chloral is by no means a specific for tetanus, yet is to be preferred to all other medicaments, and for these reasons: It is a simple hypnotic; it is not accompanied by the disagreeable consequences of morphia, especially the cerebral hyperæmia; it is easily given to children, with a very small risk of cumulative excessive action. The dose is one or two grains dissolved in the mother's breast-milk, obtained for the purpose, and carefully poured through the child's nose. The dose must be repeated with each paroxysm, until the child passes into enduring sleep. The administration by the nose is usually followed by a severe paroxysm.—*London Med. Record*, Feb. 4, 1874.

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*Sarcoma of the Kidney in an Infant.*

Dr. Jacobi presented to the New York Obstetrical Society (*Am. Journal of Obstetrics*, Aug. 1874) a tumour taken from a child 19 months old, which died under chloroform in Dr. Krackowizer's office, a few days previously. When the child was seven or eight months old a tumour was noticed in the right side, which increased perceptibly. When Dr. Jacobi first saw the child it was a year old; in the right lumbar region was to be felt a firm elastic tumour as large as one and a half fists, not painful, round, slightly movable, not connected with but adjacent to the liver, more likely belonging to the right kidney; over the tumour there was dull percussion sound; between the liver and the tumour there was a narrow tympanitic line, whereby disease of the liver could be excluded. Dr. Jacobi thought it was carcinoma or cystic disease of the kidney, the two most common kidney affections in young children. The tumour grew larger and larger; hæmaturia confirmed its connection with the kidney. The parents were told that if it continued to enlarge it would be fatal to the child,

and they therefore desired its removal. For the purpose of a more thorough investigation the child was narcotized, Dr. Krackowizer pouring ten drops of chloroform on a handkerchief, and then adding a few drops more. While the finger was in the rectum and the child was straining, Dr. Krackowizer noticed the pallid cyanotic condition of its head and face, respiration ceased at once, and the child was dead, all these phenomena—the cessation of the straining felt by the finger in the rectum, the cyanotic appearance of the head and face, and the cessation of respiration—occurring simultaneously. Death ensued doubtless partly from the chloroform and the encephalic congestion produced by it, partly from the pressure on the abdominal viscera and the impeded respiration caused by the bulky tumour. The tumour as presented is of the size of a large cocoanut, its external portion is evidently composed of the cortical substance of the kidney, the bulk of the mass has a tolerably soft consistence and homogeneous reddish appearance, and shows under the microscope the characteristic features of round-celled sarcoma, besides a large number of giant cells, many of them in the act of division. The weight of the tumour might be three to four pounds.

This is a unique case, at least Dr. Jacobi has not been able to discover a report of a case of sarcoma of the kidney in a child, or adult either, in all the extensive literature at his disposal. It is remarkable that the child presented no signs of constitutional disease whatever, being well nourished, lively, and talkative like most children at that age. Carcinoma of the kidney is not uncommon; Dr. Jacobi mentioned three cases occurring at nine, four, and two months respectively.

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## Surgery.

### *On a New Method of Curing Ulcers.*

Dr. Nussbaum, of Munich, (*Ærztliches Intelligenzblatt*, No. 14) believes he has discovered a successful mode of dealing with large indolent ulcers. He has treated sixty cases of extensive ulcer of the leg in the following manner with the best results. The patient, having been first anæsthetized, an incision is made completely around the sore from half to three-quarters of an inch from its margin, dividing the skin and superficial structures down to the muscular aponeurosis. Very free hemorrhage results from the wound, and it is necessary to fill the incision throughout its length with lint or charpie, and to apply firm compression; the charpie also acts in preventing immediate union of the incision. On the second day, the interposed lint is removed, and water-dressing is employed until cicatrization is completed. The author states that a surprising change is observed in the ulcer after the first twenty-four hours. The secretion alters from thin foul-smelling pus, very abundant in quantity, into normal inodorous pus, and the quantity becomes but small; the former ulcer diminishes very rapidly in size, and cicatrization, proceeding from the margin towards the centre, soon becomes complete. The diminution in the amount of the secretion, and the other favourable changes that take place, are explained by the fact that the incision divides a large number of engorged vessels, and that the nutritive elements, which were before carried away in the copious secretion, have now time for cell-proliferation and transformation into connective tissue. The author believes that by means of this treatment a more rapid cure is obtained, and that the cicatrix is more elastic and resistant, than after the use of ordinary methods. The plan advocated by the author resembles the method often employed with advantage in indolent ulcers with raised callous edges, of making a number of radiating incisions through them.—*London Med. Record*, April 8, 1874.

*Primary Lupus of the Conjunctiva.*

In an interesting paper on this subject Dr. H. Sattler, Assistant at Prof. Arlt's Clinique, states that it is very generally known that lupus may extend from the neighbouring parts of the face to the eyelids, and ultimately to the conjunctiva; and that owing to this disease large portions of the conjunctiva and of the lids may be destroyed, so that symblepharon posterior, lagophthalmos, ectropion, and their consequences, are produced. Upon the conjunctiva, which is in these cases always red and swollen, lupus appears as a coarsely granular and firm growth, bleeding upon the slightest provocation. It may extend over a more or less extensive part of the tarsal conjunctiva. It is sometimes ulcerated in places, and ultimately it passes over into a smooth, tendon-like and contracted cicatricial mass, by the shrinking of which irregular shortening of the lid often takes place, with inversion of its free margin, etc. The appearance of the disease is varied by the fact, that while cicatrices are found in one part, the disease itself may be actively progressing in an adjacent one. In severe cases the cornea, too, suffers, in the form of a thick pannus, or occasionally in the form of ulcers. The pannus is probably to be regarded rather as a secondary condition due to the friction of the rough conjunctiva, than as an extension of the neoplastic growth itself. A great number of such cases have come under my observation at the Clinique of Prof. Hebra.

*Primary lupus of the tarsal conjunctiva*, however, is not so well known as the above, and is a very rare disease. A case which occurred in our extern department, which I was enabled to observe for a lengthened time, was most instructive, inasmuch as the diagnosis of primary lupus of the tarsal conjunctiva, made in an early stage of the case, was confirmed four months afterwards by the appearance of lupus at the end of the nose.

The case was that of a girl, 13 years old, of a pale complexion, and imperfect development for her age. The margin of each lid of the right eye was thickened, and the ciliæ were irregular. Rather external to the centre of the free margin of the upper lid a slight depression was observable. The palpebral conjunctiva seemed considerably thickened and velvety, and in the external half of the conjunctiva of the upper lid there was an extensive growth, composed of a number of dark-red and somewhat flattened warty protuberances. This growth was separated from the remaining conjunctiva by a cicatricial band stretching from the above-mentioned depression to the retro-tarsal fold of the conjunctiva. In the lower lid there was a cicatrix extending from the margin to the reflected fold, and to the inside of this there were three pale-coloured tubercles lying close to each other, which were hard to the touch. The cornea was very opaque in its upper half, and a few fine vessels ramified over its surface.

The treatment consisted in cauterization of the lupoid growth with solid nitrate of silver, the cauterized part being afterwards carefully washed with a solution of common salt. The applications were made every second day, or at longer intervals, according as appeared desirable. Where the pannus was very thick, it, too, was touched with the crayon of nitrate of silver. Later on, and when the pannus was somewhat lessened, I found the yellow oxide of mercury ointment of great benefit, applied upon those days when the cauterization was omitted. In some cases internal treatment seemed advantageous. The girl, whose case I have mentioned, derived much benefit from a visit of two months to a watering place called Hall, in Upper Austria, where the waters contain iodine. The local treatment, however, was not neglected at the same time.—*Irish Hospital Gaz.*, Feb. 16, 1874.

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*On Deposits of Metals in the Cornea and their Treatment by Chemical Reagents.*

Dr. Herkel complains (*Journal de Thérapeutique*, April 25, 1874) that our best authors have little or nothing to say in regard to the treatment of these deposits, but, as the result of his own experience and experiments, he feel

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strongly that much benefit may be derived from a prolonged application of reagents. Thus, for the opacities caused by the salts of lead, he recommends the use of solutions of acetate of soda; for those of silver, the hyposulphite of soda. The salts of potassium would answer the same purpose; and the resinous deposits will yield to the frequent application of alcohol.—*London Med. Record*, Aug. 26, 1874.

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### *Cystoid Degeneration of the Iris.*

M. Wecker (*Annales d'Oculistique*, July and August, 1873) believes, that, quite apart from the cases of extreme anterior or posterior synechia which cause cystoid degeneration of the iris, any folding of the iris, such as occurs in partial or complete luxation of the lens, may do so. He records in this paper several instances of its occurrence.

Case I. A man, aged thirty, four weeks previously had received a severe blow upon the right eye from the branch of a tree; there was no wound of the eye but absolute blindness and excessive tenderness to the touch. The crystalline lens was dislocated into the vitreous humour, but its exact position could not be determined. The iris was tremulous, of a greenish hue, and appeared to be drawn backwards. In six weeks all symptoms of irritation had disappeared, and the man left the hospital. In six months' time he again presented himself. The front of the globe appeared curiously pointed, the cornea retained its transparency, and behind it there appeared five grayish transparent vesicles, separated from each other by deep furrows, three of them as large as peas, the others no larger than millet-seeds. In the centre, in the situation of the pupil, was a grayish opaque mass of tissue by oblique light it could be seen that the contents of the vesicles were transparent. M. Wecker considers that the retraction of the vitreous humour, altered in its structure, had encouraged a folding backwards of the iris, and the subsequent agglutination of its surfaces to each other, and asks in what does such a case differ from those known as cysts of the iris.

Case II. At the time of the seige of Paris, a woman, aged twenty, presented herself, who on the preceding day had received a blow from a spent bullet on the left lower eyelid. There was no wound of the eyelid or eyeball, but the latter had lost all perception of light, was very painful and much injected; blood in the anterior chamber prevented any examination of its interior. The removal of this by absorption at the end of three weeks made it evident that, as in the previous case, the crystalline had been displaced into the vitreous humour, and the iris was tremulous and drawn backwards. Some months later the eye had become somewhat atrophied and was no longer irritable; the front of the eye was somewhat pointed, the cornea was transparent, and the iris presented the appearance of being converted into four vesicles as large as a pea, similar in every way to those previously described.

Case III. A man had received a blow on the left eye with a fist. For some weeks the eye remained blind and painful. At the end of two months the pupillary space had become clear, and showed a dislocation of the lens into the vitreous humour; the iris was tremulous and much torn.

Eight months afterwards the eye had undergone the same partial atrophy and change in shape before mentioned. There were five gray and transparent vesicles developed in the iris, three of them as large as peas and filling the anterior chamber. The eye being perfectly quiet, no treatment was adopted.

From these observations it is clear that as a result of a folding of the borders of the iris and the subsequent agglutination of these folds, diverticula are formed, which, by becoming distended, may give rise to the condition of cystic degeneration.

In conclusion, M. Wecker believes that iris-cysts may develop—

1. As a consequence of the iris becoming entangled in a wound of the cornea, the aqueous humour being retained.

2. As a result of the formation of the posterior synechia.

3. In consequence of being drawn backwards and thrown into folds, the entire iris may undergo this kind of degeneration.—*London Med. Record*, March 25, 1874.

### *On Repositio Ciliorum for Trichiasis.*

This operation, recommended by Celsus, has again been brought to the attention of the profession by Dr. Argyll Robertson, in the *Edinburgh Medical Journal* of May. Few text-books make any mention of this simple method; and its reintroduction, about twelve years since, is due to Dr. Snellen, of Utrecht. The following is the method of operating: A very fine curved needle has the two extremities of a very fine waxed silk-ligature (or hair, as Celsus directs) passed through its eye. The needle, being firmly grasped by suitable forceps, is then passed through a narrow fold of skin, at the very margin of the lid, close to one of the inverted eyelashes. The point of introduction should be external to the point of emergence of the eyelash, but as close to it as possible; and the needle should be brought out after passing through about three-fourths of a line or a line under the skin. The needle and ligature should be drawn through until a small loop alone remains, when, by means of a fine pair of forceps, the eyelash is passed through the loop. Traction is then made on the ligature, and the loop with the entangled eyelash is drawn through the tunnel in the skin.—*London Medical Record*, July 1, 1874.

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### *On Trephining the Mastoid Process.*

In a treatise on the above subject, M. Brochin (*L'Union Médicale*, April, 1874), who has witnessed several operations followed by remarkable success, gives a history of the operation:—

In France it was first practised by J. L. Petit for caries of the petrous portion of the temporal bone. The proceeding has been absolutely condemned by many specialists, such as Itard and Bonnafont; but in the opinion of the author, while it is properly abandoned in cases of chronic deafness, it is indicated, 1. In caries of the petrous portion of the bone; 2. In abscess of the mastoid process; 3. In cases where suppuration in the middle ear spreads to the mastoid cells, either by the progress of the malady or through suppression of the discharge from the ear.

This opinion is not theoretical, but is based upon the observation of fourteen cases in hospital and private practice reported by M. Brochin, of which only one was fatal, and that from an intercurrent disease.

Mr. William Allington has had two cases of suppuration in the mastoid cells, one following a blow, and the other in a child of strumous habit, in which incisions followed by the use of the gouge gave exit to pus, and rapid recovery ensued.—*London Medical Record*, May 17, 1874.

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### *Cases of so-called Ichthyosis Linguæ.*

Mr. W. Fairlie Clarke, reported to the Royal Medical and Chirurgical Society (*Lancet*, March 14, 1874) nine cases of ichthyosis linguæ:—

The term "ichthyosis" was first applied to a morbid condition of the tongue by Mr. Hulke in 1864. In its earlier stages the disease has something in common with warts and corns, and with "papillary tumours of the gum." But it is distinguished both pathologically and clinically from these affections in two ways. (1) It attacks only the tongue and the inside of the mouth; no other mucous membrane is subject to such an affection. (2) It slowly spreads, but gives only slight inconvenience and no pain. In this state it may remain many years, but sooner or later it assumes the characters of epithelial cancer.

Ichthyosis linguæ manifests itself in an overgrowth of the papillary and epithelial elements of the mucous membrane, and it is the dorsum of the tongue which is affected in the majority of instances. In some cases the enlarged papillæ may be seen sprouting up in small groups, in others the whole of the affected surface is smooth, hard, and almost cartilaginous. It presents either a silvery or a snow-white appearance, quite different from any fur which ordinarily covers the tongue. When the disease has once manifested itself it is very persistent. Though it sometimes responds a little to treatment, and

though it varies slightly, it never wholly leaves a spot which it has once attacked.

The essential nature of the disease appears to be that of a chronic inflammation, accompanied by an overgrowth of the papillæ and a loss of power to throw off the effete epithelium. The irritation which gives rise to this inflammation sometimes acts on the periphery of the nerves, and sometimes it is situated between the periphery and the centre. It would appear that any persistent or oft-repeated irritation of the lingual branches of the fifth pair is capable of causing the disease in persons who have a strong inborn tendency to the development of warty growths under slight causes.

If a portion of the ichthyotic coating be examined under the microscope, some increase in the thickness of the epithelial layer is seen, some enlargement also of the papillæ, and a great development of the rete mucosum. Around the bases of the papillæ, and in the submucous and muscular tissues, there is a very abundant nuclear cell-growth. There is also a notable increase in the number and size of the bloodvessels in all parts. When the disease reaches the stage of epithelial cancer, the most striking feature is the development of the rete. It increases enormously at the expense of the papillæ, reducing them in many places to mere threads, and dipping down between them in the form of large club-shaped processes. Towards the termination of some of these processes the cells may be seen to have assumed a circular arrangement, forming the laminated capsules, or nests of cells, that are so characteristic of epithelioma. These points are illustrated by microscopial sections and drawings.

Nine cases of ichthyosis linguæ are related at length, some of which were under the author's own care, while others have been communicated by friends or gleaned from publications. In an appendix eight more cases are briefly noticed. Several of the cases are illustrated by drawings.

The paper concludes with some general remarks upon the disease and its treatment. 1. It is much more common in men than in women. Out of sixteen cases (one being set aside for special reasons) only one was a female. 2. It never occurs before puberty. It is an affection of early manhood and of middle age. 3. Though a venereal ulceration may occasionally be its starting-point, there is no reason to think that it is always associated with syphilis. On the contrary, it is clearly distinguished from the manifestations of that disease. 4. With regard to treatment: If the disease presents itself in a very early stage, it should be promptly and thoroughly excised. On the other hand, when it has become epitheliomatous, no time should be lost in performing an operation. But during the whole middle period the best thing that can be done for the patient is to study his general health. If any local measures are used they should be of an unirritating kind. If any jagged teeth are present they should be removed. At the same time the patient should be advised to guard his tongue against all sources of irritation, and to pay particular attention to his digestion. Under this treatment the ichthyotic coating often alters for the better, though it is never altogether removed.

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### *Galvano-Cautery in Tracheotomy.*

M. Krishaber reports (*Le Mouvement Médical*, January 10, 1874) two cases of tracheotomy. The first was in a man æt. forty-five, affected with vegetations seated in the trachea and the subglottic portion of the larynx, and occupying almost entirely the superior part of the respiratory canal. The operation was performed with the galvanic knife, and the sections were made slowly and carefully; all flow of blood ceased at once on touching with the knife the artery which produced it, and this was also the case in a profuse secondary hemorrhage, which took place some hours after the operation.

The other patient was a man, æt. sixty-three, with a laryngeal tumour, which was causing more and more intense aphonia and dyspnœa, and thus rendered asphyxia imminent and tracheotomy inevitable. The operation was conducted in the same manner, but the hemorrhage necessitated the application of a ligature, and the tracheal opening had to be made with a bistoury. M. Krishaber,

while admitting the hæmostatic power of the galvanic knife, believes that the ligature and bistoury are still preferable, as offering more security against secondary hemorrhage.—*Phila. Med. Times*, March 28, 1874.

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*Swallowing of a Shawl-pin—Passage per Anum.*

Dr. S. Caro exhibited to the New York Pathological Society (*Med. Record*, April 15, 1874), a shawl-pin (two inches long, with a globular glass head) which had been accidentally swallowed by a child twenty months old. Immediately after the accident the first physician at hand, who happened to be a homœopath, was called in, and he at once administered a large dose of castor oil. Dr. Caro, who was the regular family attendant, was then sent for and came armed with the œsophageal bristle-parachute. On examination of the throat nothing could be seen of the pin, and on introducing the instrument for the sake of exploration, the head of the pin was touched high up in the œsophagus and then slipped down into the stomach. Under the circumstances, considering it highly important that the peristaltic action of the intestines should be controlled, three drops of tinc. opii were administered every three or four hours until the desired result was obtained. As much solid food was given as the child would take. Two days after the accident the bowels moved, when the pin was passed, head downwards, without the least trouble.

Dr. J. C. Peters referred to a similar case which had occurred to him in which a shawl-pin of the same dimensions was passed in four days. In the mean time the patient was fed principally on mush.

Dr. Briddon remarked that he once removed from the neighbourhood of the hip-joint a needle which had been swallowed seven years before. He also cited the curious circumstance of a child, thirteen months old, who swallowed a shawl-pin, one and a half inches long, the face or ornament of which was a miniature velocipede and rider. The patient was sent to him by Dr. Aigner. On examining the fauces the foreign body was felt firmly impacted across the glottis. A forceps was introduced and one wheel of the velocipede came away, and it was only after a great deal of difficulty that the entire foreign body was extracted. Notwithstanding the position of the obstruction, there was no difficulty in breathing.

Dr. Knapp believed that so long as a pin had a head there would be no difficulty in its passing through the intestinal canal. The weight of the head was generally sufficient to determine its direction in the long axis of the gut, and if this were not the case and the pin actually penetrated the side of the canal, the head would prevent its going further and the peristaltic action would eventually get the foreign body in the best relative position for passage, viz. with the head downwards.

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*On Cysts of the Posterior Wall of the Bladder in Man.*

In the *Anzeiger der k.k. Gesellschaft der Aertze in Wien*, January, 1874, Dr. Englisch has a communication on these tumours. If a sufficient number of preparations be examined, there are not unfrequently found, in the space between the two vasa deferentia, and less often on the vesiculæ seminales, cysts of various sizes. He describes them as consisting of four different kinds.

The first class of cysts corresponds with the mesial line, and lies in the musculo-fibrous membrane, which binds together the vasa deferentia.

The second kind lies more to the side, near the vas deferens, and is connected with it by means of a process of connective tissue.

The third form lies partially in the prostate, and corresponds with an enlarged sinus pocularis, if its orifice be closed.

A fourth form is connected with the vesicula seminalis, and has no attachment to the vas deferens.

These cysts do not only exist in adults, but are also met with in children, and it has been clearly shown that the first three kinds exist in newly born infants, and become developed later on.

It is probable that the cyst lying in the middle line corresponds with the remains of the Müllerian canals, and that those of the second form proceed from the development of the orifice of the vas deferens, or represent the remains of the cul-de-sac of the Wolffian body.

The third form is developed when the cul-de-sac of the sinus pocularis, which commences at the colliculus, extends far backwards, and becomes distended.

The fourth species is found in connection with the results of inflammation of the vesiculæ seminales, so that the closure of a sinus is peculiarly a result of an inflammatory process.

So long as the cysts are small, they cause no particular annoyance, although they may, as in instances proved, distend the recto-vesical pouch and cause retention of urine.—*London Med. Record*, April 22, 1874.

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*Spina Bifida cured by Injection.*

J. Ross Watt, M.B., Consulting Surgeon to the Fever Hospital, Ayr, N.B., reports (*British Med. Journ.*, Jan. 31, 1874) the case of E. G., aged three years, who had a spina bifida tumour, which was wholly covered by true skin, stood out with a prominence of nearly four inches, and measured thirteen and a half in circumference. It was very sensitive to the touch, became tense when the child cried, and palpation discovered a perfectly fluid condition of its contents. It was slightly pendulous when the child was erect, and gave her a ludicrous, although at present rather fashionable, appearance when dressed—the projection at her age being unlooked for.

Her mother stated that it was like a walnut at birth, and had increased gradually; that she walked at two years; was now active, although not firm on her legs, and easily knocked over; that she enjoyed excellent health, but was constantly annoyed by escapes from the bladder and rectum; and that she had always been advised to let it alone.

The treatment of the case was by injection of solution of ten grains of iodine and thirty of iodide of potassium, in an ounce of glycerine; and was briefly this. Two tentative tappings with a medium canula, of respectively twelve and ten ounces of clear fluid, were made, with an interval of eight days, both being followed by an irritable and feverish condition of the child, and gradual refilling of the tumour to its original size. Ten days afterwards, another ten fluidounces were removed, and half a drachm of the solution injected. The opening was instantly closed on each occasion by a layer of lint soaked with flexile collodion. This last operation in a few days made the tumour tender, and caused the child to be feverish, restless, and extremely excitable, with decrease of appetite, milk and soups alone being taken. Ten days after this first injection, the tumour was very slightly less, and eight ounces were then removed, followed by injection of a similar quantity of the solution. This gave rise to even more severe irritative symptoms of the nature described; but a fortnight later showed the tumour only one-third of its original size, although still sensitive and painful when interfered with. At that time, about five ounces were removed, followed by a third injection of half a drachm; this caused cessation of any further formation of fluid, and a gradual absorption began, which, at the end of twelve weeks from the first interference, presented a roughened, darkened, and thickened condition of skin, quite normally sensitive to the prick of a needle, replacing the tumour and closing the spinal aperture with an apparently gelatinous mass.

The treatment extended over nearly seven weeks, and the measured fluid removed amounted to forty-six ounces—a larger quantity, to my knowledge, than from any previously successful case. Half a drachm of the solution was deemed sufficient for each injection, owing to the large extent of sensitive surface to be dealt with; and the irritative symptoms developing therefrom quite justified the precaution taken.

This, Mr. Watt's second case, with Dr. Morton's, makes four successes, all that have been so treated; and, without appearing too confident of further success, the result is very hopeful and gratifying to the introducer of this method of treatment.

The patient is now very active on her feet (amusing herself, and standing as much consequent fatigue daily as her healthy companions), growing rapidly, and the sphincters are now almost wholly under control; cold sea-water baths being persevered with.

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*Blood Cyst of the Hand.*

Mr. T. Harrington Haward read, before the Clinical Society of London (*Med. Times and Gaz.*, April 11, 1874), notes of a case of this. The patient was a man, aged forty-three, married, and in good health, and with a good family history. For three years he had suffered from tingling and pain in the right forefinger, and for two years had had a gradually increasing tumour on the ball of the right thumb. This was punctured, and only blood escaped. He was admitted into St. George's Hospital, and the tumour removed by Mr. H. Lee, the limb being bandaged after Esmarch's method. The tumour was examined by Mr. Haward, who found it to be a cyst with thick walls of gelatinous appearance, containing in its interior smaller masses of material resembling that of the cyst-wall, and some old blood-clot. Microscopically, the cyst-wall and the contained masses were found to be composed of spindle-shaped-cells with oval nuclei, closely placed in a very scanty intercellular material. The clinical histories of cases of blood-cyst were shown to exhibit very various characters, some cases doing well and others exhibiting decidedly malignant characters, this difference depending upon the character of the cyst-wall. The different kinds of blood-cyst having been spoken of, the author drew the practical conclusion that, in all such cases, the growth should be very completely removed, and, even then, that a guarded prognosis should be given.

Mr. P. Hewitt had a similar case. A lady had a large fluctuating tumour in the palm of the hand. He thought it was a bursal swelling, and opened it. Bloody fluid appeared, and in a few days fungating growths, which bled much, began to sprout from the edges. He amputated the forearm. Ultimately she died of phthisis the year after, without any return. Another lady had a dark-looking cyst in her breast for eighteen years. She had punctured it from time to time, and let out fluid. She got tired of this, and had it removed. The breast was seen to consist of a single large cyst. She remained well for years, but died of cancer in the axilla. There was no malignity in the cyst.

Mr. T. Smith mentioned the case of a boy who fell and struck his calf. He was seen with a collection of blood in the calf. This was removed, but it accumulated again and again, and finally turned cancerous. The limb was amputated, but the child died of internal cancer.

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*Amputation of Penis for Epithelioma.*

Dr. Watson exhibited, at a meeting of the Medico-Chirurgical Society of Edinburgh (*Edinburgh Med. and Surg. Journ.*, Feb. 1874), a penis which he had removed from an elderly patient on account of epithelioma commencing in the frenum. The example was interesting, as bearing upon the influence of congenital phimosis in the production of such disease. Here the phimosis followed upon the thickening of the prepuce, and did not precede the development of the disease. Dr. Watson amputated the organ in a somewhat novel manner, which he introduced into operative practice some years since. This procedure consists in amputating by direct section, then dissecting up the corpus spongiosum urethræ and turning it out through a slit in the cutaneous tissues clothing the under surface of the limb of the penis. The bleeding was staunched by transfixing the corpora cavernosa by a double catgut ligature, which being divided, each end was tied so as to include each half.

*On Amputation in the Continuity of the First and Fifth Metatarsal Bones.*

Dr. Desprès, Surgeon to the Hôpital Cochin, points out (*Bulletin de Thérapeutique*, Jan. 30, 1874) that, for lesions of the metatarso-phalangeal joints, disarticulation of the phalanx is not sufficient, and that most surgeons are of opinion that the head of the metatarsal bone should be removed at the same time; when the whole metatarsal bone is removed, the tarso-metatarsal joints are opened, which is a disadvantage. The many operative proceedings recommended have for their object to remove the cicatrix from the influence of subsequent pressure, or at least to avoid a plantar cicatrix. Notwithstanding the precautions taken, the cicatrix is found sometimes on the side of the foot where it is exposed to pressure, or adherent to the end of the bone, where it is sure to be painful. The author adopts a method which he has seen Richard employ, and calls it a racquet-shaped incision with external flap. He adopted it in four cases recently with good results. An incision is made commencing near the prominence corresponding to the posterior extremity of the metatarsal bone, easily recognized by a distinct elevation under the skin; the cut is made to pass obliquely upon the dorsum of the foot until it comes to the base of the toe by an almost semicircular incision, with the convexity turned to the middle line of the foot; the incision is then continued around the base of the toe and so as to return to the first incision. The flap thus formed is dissected from the bone; that done, the metatarsal bone is encircled by an incision with the bistoury, in order to separate the soft parts. Regard being had to the age of the patient and the resistance of the bone, either Liston's forceps or a handsaw is used; in the latter case, a retractor must be employed to protect the soft parts.

The operation is stated to be easy, and the end of the divided bone does not approach the cicatrix. An account of four cases is then given, the subject being in each case able to walk afterwards in an ordinary shoe without any difficulty.—*London Med. Record*, April 8, 1874.

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*Exsection of the Hip-Joint.*

Dr. Lewis A. Sayre, in a paper recently read before the New York Medical Library and Journal Association (*Medical Record*, Aug. 15, 1874), expressed his conviction that in the vast majority of cases, hip-joint disease has a traumatic origin. The child receives a strain, a blow, a concussion, some injury which causes pressure upon the bloodvessels of the head of the femur or acetabulum, etc. etc.

It is something of that order which excites inflammatory action that goes on to the production of effects which we see developed during the progress of the disease. It seems to him it is just here that there has been this fatal error with regard to the propriety of the operation; namely, the almost universal belief that the disease is essentially constitutional in its nature. Taking this view of the question, the treatment of these cases by adopting constitutional measures *alone*, administering remedies for the purpose of rectifying a local injury, is, in his opinion, entirely wrong, and the results obtained by that form of treatment prove it to be so.

He maintains that if the disease is recognized early, it can by appropriate treatment, such as extension and counter-extension, properly applied and continued, perhaps assisted by some form of moderate counter-irritation, perhaps by the application of leeches, be brought to a favourable termination without any operation at all. Those forms of counter-irritation which are sometimes resorted to for the purpose of keeping up a continuous discharge, such as setons, etc., he does not approve of. The actual cautery is a most excellent and serviceable form of counter-irritation, and the form which he usually employs unless there are some special objections to its use.

When, however, the disease has so far advanced that the case falls under any of the indications which are to be enumerated, then he regards the operation not only as justifiable, but that it is the duty of the surgeon to perform it if possible.

Before adopting any plan of treatment, however, it is essential to arrive at a correct diagnosis. For this end it is absolutely necessary during the examination that the patient be placed upon the back, upon a hard table, with the spinous processes touching the table. Placed in this position, if the pelvis, trunk, and extremities are in a normal relation to each other, two lines, one drawn from the centre of the sternum to the centre of the symphysis pubis, and the other drawn from the anterior superior spinous process of one ilium to that of the other, will cross each other at right angles, and the extremities can be brought into a position of parallelism with each other, and the popliteal spaces will touch the table.

In the first stage of the disease, the limb is slightly abducted, slightly flexed, the foot is rotated outwards, and the toes are slightly everted.

In the second stage, the same symptoms are present, except that they are considerably increased. There is increased flexion, abduction, eversion of the toes, and rotation of the foot outwards. These symptoms are present after suppuration or extensive effusion has occurred within the joint, and are due to the fact that the pressure upon the inside of the capsule has caused it to unfold itself, as it were, compelling the limb to assume this peculiar position to accommodate the increased amount of fluid within the joint. This is the most painful period of the disease, and continues so until rupture of the capsule occurs.

When this latter takes place, the real deformity incident to the third stage of the disease begins to be developed. In this stage the limb is adducted, the foot is rotated inwards, the toes are inverted, and the limb becomes shorter. It is taught that luxation occurs in this stage; but Dr. S. has seen only a single instance among all the cases upon which he has operated, in which luxation has been present. The head of the bone is *diminished* in size by the process of absorption, and the acetabulum is *increased* in size, which permits of considerable displacement. It is also true that when the acetabulum becomes very much absorbed, the capsule and the periosteum become displaced, and the head of the bone is invested with its capsule in a new position upon the ilium. These changes may take place through the process of absorption, but as a rule there is no proper luxation.

When the disease has passed into the third stage, the case must be cured, if cured at all, either by the operation of exsection, or by nature's method.

If nature is left to cure the case without assistance, excessive suppuration must occur, and frequently patients die from the exhaustion incident to it.

The deformity which remains when nature effects a cure, is one with which all are familiar.

The indications for the performance of the operation are:—

1. If there is denuded bone present, the operation is justifiable.

2. If the discharge is excessive, and is increasing, the operation is justifiable.

If the discharge is diminishing, and the patient is improving in health, the case may perhaps be left to get well by nature's method.

3. If there is danger of perforation of the ilium, the operation is justifiable.

This point can be settled by rectal examination. A spongy feel or sense of fluctuation can be detected as the finger passes over the plane of the ischium if perforation is threatened. In such cases it is better to operate than to run the risk of having perforation occur.

The operation is to be performed as follows: Anæsthetize, and place the patient upon the well side. Carry the point of a strong knife home to the bone at a point midway between the anterior superior spinous process of the ilium and the top of the trochanter major. Holding the knife firmly upon the bone, carry it through the tissues in a slightly curved direction, to a point midway between the centre of the trochanter and its posterior border, and then continue the incision from two to three inches farther down upon the thigh, curving it slightly forward. Cut through the periosteum freely. Make a second incision through the periosteum at right angles with the first, extending as far around the bone as can be conveniently reached, at a point nearly opposite the lesser trochanter. Introduce the elevator, and peel up the periosteum, until it is reflected, to the digital fossa, at which point it will be necessary to cut the muscular attachments. Continue the reflection of

the periosteum until the bone can be turned out sufficiently far to permit the introduction of a narrow saw (a saw is always to be used), and then remove the bone below the trochanter major. More of the bone must be removed if found diseased below this point. It is better to remove the trochanter major even though it be not diseased, because, if left, it will obstruct free discharge of pus. If the disease has been of long standing, and nature has formed a large amount of involucrum, it may be necessary to first saw the bone off before it can be turned out.

It has happened to Dr. S. in two cases that the acetabulum had been perforated, and a portion of the femur had become engaged in the opening. Fixed in this manner, the acetabulum offered so much resistance that, in both instances, the femur was fractured by the force used for luxating the bone.

All dead bone is next to be carefully removed from the acetabulum, taking great care not to injure the internal periosteum.

Wash out the wound, pour it full of Peruvian balsam, tampon with oakum in such a manner as to permit a perfectly free discharge from the bottom of the acetabulum, apply one or two sutures, and then dress the child in the *wire-cuirass*, which is a modification of Brower's wire-breeches. Dr. S. deprecates tamponing the wound with cotton, for he feels certain that one of his cases was killed by accidentally having it used.

The application of an India-rubber bed to the cuirass adds very much to the comfort of the patient. The well limb is to be dressed first, and made a solid column upon which to make counter-extension for the diseased limb.

Place the anus of the child in proper relation with the opening in the cuirass. Extend the well limb, and fasten the foot of the foot-piece by means of a roller bandage. Place a moderate splint, such as a folded newspaper or piece of soft pasteboard, over the knee to prevent flexion. Carefully secure the whole with the remainder of the roller bandage, which is to pass over the entire limb and perineum. Apply the bandage with great care, in order to avoid wrinkles and undue pressure. The requisite amount of extension is made by means of the thumb-screws attached to the foot-piece.

The foot of the diseased limb is to be fastened to the foot-piece by means of broad strips of adhesive plaster, which extend along the sides of the leg and reach *above* the knee, in order that traction shall *not* be made upon the lateral ligament of the knee-joint, but upon the thigh. The plaster is secured to the limb by means of a roller bandage so applied that all wrinkles in the plaster shall be avoided. Extension to the diseased limb must be *gradually* applied.

The tissues about the wound should be firmly supported with a bandage for the purpose of preventing infiltration of pus. The first dressing of the wound may be made at the end of forty-eight hours. Subsequently the dressing may be repeated according to the amount of discharge, etc. In the subsequent dressings it is important to keep the periosteum well stuffed with oakum in order to permit the deposit of sufficient bony material to finally bear the weight of the body. The well limb must be undressed at least once a week, free motion restored to the joints by passive movements, and then replaced in the cuirass.

If the wire-cuirass cannot be easily obtained, a long Haggerdon's splint may be employed, with the modification of adding a foot-board.

It is possible to treat a case upon a firm bed, making extension by means of a weight and pulley. This, however, necessitates continued confinement of the patient, which is undesirable, if it can be avoided.

The children are kept in the wire-cuirass, as a general rule, about six weeks. At the end of this time the short splint which he has devised is applied, and the child permitted to go about without the assistance of a crutch.

If the thigh is so short that this splint cannot be advantageously applied, Taylor's long splint may be employed, or a modification of that splint, by which a movement of abduction is secured, and rotation outward at the same time, by means of screws adjusted to the joint in the instrument opposite the hip-joint.

Since Dr. S.'s first operation he has operated forty-four times. The results which have been obtained have been obtained upon cases taken indiscriminately. The percentage of mortality is so small, he believes that the operation is not

only *justifiable*, but, if the cases could be selected, and the operation performed at the most proper time, there is much better prospect of obtaining good results.

*Analysis of 44 cases of exsection of the hip-joint.* Males 28, females 16.

The acetabulum was perforated in 30 cases.

The disease could be traced to traumatic causes in 36 cases.

TABLE.

| Age of patient. | No of cases. | Died before wound healed. | Recovered. |
|---|---|---|---|
| Under 5 years . . . | 8 | 1 | 7 |
| Between 5 and 10 years . . | 19 | 2 | 17 |
| " 10 " 15 " . . | 13 | 5 | 8 |
| " 15 " 20 " . . | 2 | 2 | |
| " 20 " 30 " . . | 1 | 1 | |
| " 30 " 50 " . . | 1 | | 1 |
| Total . . . . . | 44 | 11 | 33 |

Of the 33 cases which recovered, all are now living except 2.

One of these died of marasmus and cholera infantum six months after the wound had healed, and two years and seventy days after the operation.

The other died of phthisis two years after the operation. The wound had been healed more than a year.

The following is a record:—

Of the 11 cases which died before the wound healed—under five years of age: one died of dysentery two weeks after the operation.

Between five and ten years: one died of exhaustion in two weeks, and one died of exhaustion on the twenty-fourth day after the operation.

Between ten and fifteen years: one died of exhaustion on the eighth day; one died from tetanus on the fifteenth day; one died on the fourteenth day of double pneumonia; one died at the end of nine months of exhaustion, six inches of the shaft of the femur having been removed at a second operation; and one died at the end of seventeen months of dysentery. In this case, at the time of death there was limited motion, and only a very slight discharge from two sinuses at the back of the thigh.

Between fifteen and twenty years: one died on the fortieth day after the operation, of sunstroke. Wound very nearly healed. One died at the end of three weeks, of amyloid degeneration of the kidneys.

Between twenty and thirty years: one died at the end of eleven months, from fatty degeneration of the liver and kidneys. Wound nearly healed. Three inches of new bone had formed.

The cases now under observation, upon which the operation has been performed, are certain to recover, with a single exception.

In the case in which a second operation was performed and six inches of the femur removed, my present opinion is, that amputation at the hip-joint would have been the more favourable operation.[1]

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### *On Spontaneous Fractures and Dislocations in Ataxic Patients.*

Under this title M. Bergeron (*Le Progrès Medical*) has just published an interesting article which is based on a fact that M. Richet mentioned in one of his last clinical lectures. The readers of the *Progrès Medical* are already acquainted with the subject, for they have had the first communication made by M. Charcot to the Société Anatomique.

Dr. Charcot's case, which gave rise to discussion in which several members

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[1] Since the reading of the paper, the forty-third case, the one referred to above, has died at the end of the eleventh week after the operation. The specimen was presented at the New York Pathological Society, April 8, 1874. The patient was ten years of age. The acetabulum had become covered with new material, and four inches of dead bone at the upper extremity of the femur had been surrounded by a heavy involucrum, which had been rounded off at its upper extremity so as to fit the acetabulum in the most perfect manner.

of the Society joined, has been since reproduced in all its details in the *Archives de Physiologie* (Jan. 1874), and has besides been inserted by M. Forestier in his Inaugural Thesis (*Thèses de Paris*, 1874). As in cases already mentioned, in the one related by M. Richet, the fracture occurred spontaneously without any traumatic cause, and the union was rapid. On the patient dying M. Richet found an ostitis, which had thinned the bone, and to which he attributed the occurrence of the lesion. This ostitis, which would itself seem to be dependent on the morbid changes in the spinal cord, and at the same time the cause of these spontaneous fractures, would also constitute a condition eminently favourable to a rapid reunion. It is possible that this explanation may be correct. However we ought to receive it with some reservation, and for these reasons: 1. Because in Dr. Charcot's first patient, one of the fractures—that of the left thigh—did not unite; and 2. Because in old men in which an analogous ostitis occurs, as M. Richet remarks, the formation of a callus takes place very slowly, whenever it does take place.

However unimportant these explanations may be, the fact recorded is nevertheless extremely instructive. It remains to be studied, and for the future to decide.

M. A. Bergeron concludes his article with some remarks on spontaneous dislocations in patients suffering from locomotor ataxy. This is a new subject in surgery, but it dates back six years, when M. Charcot made known, for the first time, the occasional existence of this complication with sclerosis of the posterior columns of the spinal cord. A patient suffering from locomotor ataxy, says M. Bergeron, was admitted under the care of M. Béhier. Without any exertion or effort, a dislocation of the shoulder-joint ensued. The patient died of the ataxy, and at the necropsy there was found, not a pure and simple dislocation, but a disruption of the head of the humerus, which, thus deprived of its ligaments and muscles of attachment, had become displaced, and simulated a dislocation.—*London Med. Record*, July 1, 1874.

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*On Dislocation of the Thumb at the Metacarpo-phalangeal Articulation.*

Dr. Langer (*Allgemeine Wiener Medizinische Zeitung*, March 3, 1874) describes the results of some experiments on this dislocation. He induced the luxation on the dead body, and, after having frozen the parts and sawn them through, made the following observations. He distinguishes an incomplete and a complete luxation; the latter is when the base of the first phalanx is dragged up upon the head of the metacarpal bone. The obstacle to reduction is due to two factors, ligaments and muscles. His remarks refer to this form of the accident. Complete rupture of the loose capsular ligament invariably occurs, and of both lateral ligaments obliquely.

Dupuytren and Günther advised the subcutaneous section of the latter, since they form, with the volar part of the capsule and the sesamoid bones, an obstructing ring: this holds good for the incomplete, never in the complete form, which, as Dr. Langer states, occasions complete rupture of the capsular and lateral ligaments.

Further obstacles to reduction moreover exist in that, by the upward dragging of the phalanx, the two interposed sesamoid bones fix themselves firmly on the articular edge of the head of the metacarpal bone, that there a loose portion of the capsule is turned over, and that, in place of the normal horizontal direction, the muscles of the thumb come to lie in an oblique, indeed nearly vertical direction to their insertion on the other side of the joint, whereby they fix the phalanx in this new position.

The treatment must consist of either powerful extension, forced flexion, or the so-called impulsion (*i. e.*, forward pressure against the base of the phalanx, at the same time powerfully dragging it back), and, failing either of these, operation. This consists in making an incision in the volar surface, and removing a piece of the head of the bone, with, if necessary, the sesamoid bones also, and finally fixing the thumb by means of a splint.—*London Med. Record*, April 22, 1874.

*Local Osteomalacia of the Leg.*

Dr. Czerny, of Freiburg, relates a case of this uncommon affection, and makes some interesting remarks which are worthy of a somewhat full report. The paper is accompanied by a wood-cut, illustrating the deformity, which at first sight looks like a badly healed fracture.

S. Rafael, aged twenty-two, served as a soldier during a recent war, and made the forced march which preceded the siege of Belfort. At that time he felt and complained of shooting pains at the inner side of the left ankle, which rendered necessary a short stay in the hospital. He soon became better and continued his service. After the war, he worked as a mechanic. He came to the clinic on March 12, 1872. There was some swelling at the inner side of the ankle, which was not sensitive to pressure. He complained that, after long standing, there was great pain in both ankles. The affected foot was somewhat flatter than the other, which made Dr. Czerny think it might probably be a case of commencing talipes valgus. Rest and moist applications soon relieved the symptoms, and the patient was discharged on March 27 with a Stromeyer's shoe.

Some weeks later he returned to the hospital, and complained that the improvement was only temporary, that the pains were now in the lower part of the shin. There were slight œdema and pain on pressure, and he could not use his foot for any time, so that on May 6 he was admitted into the clinic. At this time there was a slight bending of the tibia, which was thickened at the anterior edge. Dr. Czerny then thought it was a case of chronic osteitis, and applied a gypsum bandage, leaving an opening over the seat of pain, where iodine was applied. The pains disappeared after some weeks; and, as the patient wished to be discharged, he was dismissed with an isinglass bandage.

During his stay in hospital the deformity did not increase, but afterwards the patient did not have his bandage renewed, and through constant use of the leg it became considerably bent. On February 8, 1873, he was readmitted. The left tibia at its lower third was bent at an obtuse angle, so that the tendo Achillis was strongly arched inwards. At the seat of the greatest bending, both bones appeared thickened. On attempting gently to bend the bones with the hands no pain was produced, but there was no yielding. The muscles of the calf were rather weaker than those of the opposite side. The foot appeared as if slightly affected with talipes equino-valgus.

The man could walk with the help of a stick, but was soon tired, and complained of pain in the ankle after long use, which Dr. Czerny thought to be probably due to stretching of the ligaments. In other respects the man appeared in good health, and there was no affection of the other bones.

On July 12, 1873, the condition had not changed. In case the functional disturbance should increase, Dr. Czerny suggested forcible straightening of the bones with, or without, osteotomy; but the patient was loth to acquiesce.

Cases of this kind are so rare, that it is worth while to quote those which one can find scattered in medical literature. Scoutetten (*Gazette Médicale de Paris*, 1841, p. 428) reports the case of a tailor, aged twenty-five, who was otherwise in good health, but who suffered from severe pains in the lower portion of one leg, which was followed by gradual bending of the part, so that finally it gave way or cracked at a right angle. The foot was in the position of extreme valgus. The bones firmly united, so that he became a postman, and walked eight or ten miles daily. The ankle-joint was healthy, and the deformity affected the bones just above the joint. Scoutetten ascribes this deformity to a partial osteomalacia, which developed itself without any known cause, and considered the case unique.

Solly (*Medico-Chirurgical Transactions*, vol. xxvii., 1844) describes two cases which, he concludes, were due to local osteomalacia, and which appeared to belong to this category. In a man aged thirty, one leg gradually became bent, the integuments thickened and ulcerated, and the general health was disturbed so much that amputation was performed. The tibia and fibula showed very loose lamellæ, which were very thin and fragile, filled with a soft red mass

Another man, aged thirty, suffered manifestly from softening of one thigh, which was fractured from a very slight cause. The bone was much thickened and bent. An apparatus was procured for him, by means of which the weight on this side was transferred from the thigh to the pelvis, and thus he was enabled to walk and to work.

Mosetig (*Wiener Medizinische Presse*, 1868, No. 4, p. 89) describes, under the name of osteo-halisteresis, a case of local softening of the bones of the leg. The patient, aged twenty-one, had the year before, during dancing, suddenly felt a very violent pain, which, however, did not prevent him from continuing to dance, after a short rest. Since that time he had occasionally felt slight pains, and observed, for the first time, about Christmas, 1866, that his leg commenced to bend a little above the malleoli. The curvature increased constantly, and at last rendered walking impossible, so that the patient entered the clinic in July. The direction of the curve was outward, and corresponded to an angle of one hundred and thirty degrees; the foot was in a valgus position. The bones were not enlarged at the seat of curvature. They were smooth, and there was no solution of continuity. By daily cautious bending and the application of wooden splints, the limb was quite straight in four weeks. After this the patient was further treated with splints, etc., until the bone became perfectly firm. R. Volkmann adds the following remark. The assumption of the author that in such cases of gradual curvature of the bones we constantly find a halisteresis, *i.e.*, a partial decalcification while the cartilage remains normal, rests on an error. Much more frequently there shows itself, as so-called rarefying osteitis, an increase of the medullary space, and in necrosis (in which Mosetig saw curvatures twice), there was usually an internal fracture.

Weinlechner (*Wochenschrift der Gesellschaft der Aerzte in Wien*, vol. 25, p. 21) saw two cases. A strong butcher, aged between twenty and thirty, had a curvature of the right leg and pain, which prevented him from walking. No injury had preceded it. The bone exfoliated (*federte*). A labourer, aged nineteen, who had been ill for nine months, had both legs bent, the one with the apex of the angle outwards, the other inwards. Here also pain existed. The bone exfoliated. Splints and good nourishment formed the therapeutics. On dismissal, both legs were still pliable.

The cases of Scoutetten, Mosetig, and Weinlechner are extremely like Dr. Czerny's. In all six patients, who were strong men of the labouring class, and were of that age in which the growth of the length of the skeleton ceases, a curvature of the legs above the ankle was gradually developed, and was accompanied by pain, which did not, however, prevent the use of the limb. The limbs were at first pliable, but in some cases became unpliable and hard.

We must here suppose a sclerosis of the bones, if we take into consideration the perfect recovery of the functions in such unfavourable mechanical conditions as in the case of Scoutetten. We have no certain data on the cause of this peculiar affection, if we are not to consider as such the much maligned cold-cathing, which occurs commonly in dancing, or in long marches in deep snow (Dr. Czerny's case). Mosetig assumes, in his case, an injury. In none of the patients is a dyscrasia or a hereditary predisposition mentioned. Solly's first case seems also to belong to this class, but it is not very clear (as given in Hodgson's short report) how long the disease had lasted, whether the disease of the bone had gone on to the formation of pus and ulceration of skin, or whether an ulcer of the skin had been developed at the place of curvature and independent of it, which became so burdensome to the patient that he submitted to amputation. It is probable that the patient could not use his leg for walking, otherwise he would not have so readily submitted to amputation. Unfortunately, we cannot on this account learn anything from this meagre anatomical result, which, so far as Dr. Czerny knows, is the only one which has been examined; and he cannot find out whether Volkmann was induced by other anatomical researches to communicate his remarks concerning this disease.

Solly's second case must rather be ascribed to a senile osteoporosis, and cannot well be explained without an anatomical examination. Cases of local osteomalacia of individual bones, as of the sternum, cranial bones, etc., which

always end fatally, cannot have anything in common with this disease. The fact of the softening frequently ending in sclerosis might make one incline to the diagnosis of delayed rachitis, but the affection in such cases was a purely local one, and there was more inflammation than in rickets. The name osteo-halisteresis only explains a part of the diseased process; as all the characters of osteitis ending with sclerosis were present, the term osteitis deformans seems more applicable.

Dr. Czerny thinks that, when attention has been sufficiently drawn to this disease, cases will be more often recognized. Syphilis may be a cause of bending of bones; and shortly after this case one due to syphilis came under Dr. Czerny's care, and was cured by iodide of potassium, splints, and rest. Syphilis may be suspected in cases of osteitis deformans; and iodide of potassium should be tried.

Mr. Reeves appends to this paper the report of the case of a woman, aged fifty, but looking older, who is now among his out-patients, and came complaining that her legs were bending. One—the right—had commenced to do so three years ago, and the left only during the last fourteen months. Both tibiæ were considerably curved forwards, and at first sight he was inclined to regard the case as an old-standing one, *i. e.*, that she had been the subject of rickets when a child, and that her history was not reliable; but at a subsequent visit she was questioned very closely, and her daughter said that her mother's legs had only commenced to curve during the last three years. This induced him to regard the case as one of so-called senile rickets, and as several features resembled those of the cases of Dr. Czerny, he has thought it well to append a brief notice of it.—*London Medical Record*, March 11, 1874.

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*On the Treatment of Rickety Deformities of the Legs by Operation.*

Mr. Howard Marsh read a paper on this subject before the Royal Medical and Chirurgical Society, February 10. The author gave an account of four cases of rickety deformity of the legs which he had treated by operation. In two of them the curvature was outwards, in one outwards and forwards, and in one almost directly forwards. In the first three cases a tendon knife was passed down to the tibia, where the concavity of the curve was greatest, and the periosteum was divided transversely. A fine saw was next introduced, and the bone partially divided, and then, by a somewhat suddenly applied force, snapped across; the fibula was either bent or broken, and in one of the operations the tendo Achillis was cut. In the two cases in which the curvature was outwards the legs are now straight; in the boy whose curvature was outwards and forwards, and in whom the treatment was interrupted by an attack of scarlet fever, the deformity, although much diminished, is not wholly removed. In none of the patients was the operation followed by any serious symptoms, and, except in the boy who had scarlet fever, convalescence was complete in about a month; in him it was complete in about six weeks. In the fourth case, in which the bones of the legs were curved almost directly forwards, and in which the deformity was so extreme that the boy could only walk a few steps at a time, a wedge of the bone was taken out of the tibia with a chain-saw, the tendo Achillis was cut, and the fibula broken in one leg and cut with bone-forceps in the other. These operations, which were performed, the one on April 8, the other on October 4, 1871, were not followed by any dangerous symptoms, but small disks of bone became necrosed, and were slowly separated from the cut ends of the tibia. Union was firm in one leg in three months; in the other, in which it was much delayed by the tedious separation of the necrosed portions of bone, in six months. The legs are now straight, and the boy walks without impediment. The paper was illustrated by photographs and casts of the limbs before operation, and the cases were shown.

Mr. William Adams said that the first three cases—those of subcutaneous division of the bones—were especially interesting, the operation was so easy and innocent, and followed only by good results. He believed this operation would come into more general use in suitable cases. In regard to the fourth case, it is seldom that this operation would be applicable—removing a large

wedge of the tibia and cutting the fibula. Mr. Adams had seen the operation performed by Mr. Little in the National Orthopædic Hospital six years ago, in a woman; the proceeding was a severe one; the future history was tedious, but the ultimate result very satisfactory. Probably Mr. Little introduced the operation into England. In all Mr. Marsh's cases there was the peculiar feature that the disease was nearly limited to the bones of the legs proper; and where the thigh-bones were bent, they had improved by the rest after operation. He believed himself in the spontaneous straightening of rickety bones. Yet in deformities of the thigh-bones in girls he insists upon recumbency for one or two years, on account of the effect upon the pelvis.—*Med. Times and Gaz.* Feb. 21, 1874.

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## Midwifery and Gynæcology.

*On the Means employed at the Preston Retreat for the Prevention and Treatment of Puerperal Diseases.*

Dr. William Goodell, Physician-in-Charge of the Preston Retreat, and Clinical Prof. of Diseases of Women and Children in the Hospital of the University of Pennsylvania, contributes to the July and August numbers of the *Obstetrical Journal of Great Britain, American Supplement*, the following interesting paper on the above subject:—

He says: "It was not my purpose to publish the statistics of the Preston Retreat until one thousand cases of delivery had been reached. But, in view of the fatal epidemic of puerperal fever now prevailing in Philadelphia and in the city of New York, I have so far yielded to the wishes of my friend, the editor of this journal, as to give a short account of the precautions taken in this institution to guard against the occurrence of puerperal diseases. This I am the more emboldened to do, because the peculiar measures adopted have apparently made the statistics of this institution compare very favorably, not only with those of like charities, but also with those of private practice. They have also kept its wards free from any epidemic of puerperal fever; although, during the past three years there has been more or less of this disease in this city, and, within the past two months, a number of deaths from this cause have occurred in the immediate neighbourhood of the building.

"The Preston Retreat is a small lying-in hospital for reputable married women. The yearly average has thus far been about one hundred labours, but it is now rapidly increasing. It contains four wards, each with a capacity of 9153 cubic feet, and each furnished with five beds, of which not more than four are generally occupied at one time. The ventilation in winter is obtained by the escape of the cold and foul air through an old-fashioned fireplace, in which a jet of gas is kept constantly burning, and by the free admission of pure air, which has been heated in the basement by passing around steam-chests, with large radiating surfaces. In summer, the admission of pure air depends exclusively upon open doors and windows, and the ventilation is, consequently, less perfect than in winter. In the spring and autumn months, there are many days in which the temperature is too warm for the free admission of heated air, and yet too cold for open windows. These are, therefore, the two seasons of the year which I dread the most, and in which I avoid, as much as possible, crowding the wards.

"The wards are used invariably in rotation. By close management, and by crowding walking patients together, one of these wards in its turn stands idle for two or three weeks. During this time the doors and windows are kept open. Before it is again occupied by patients, the walls, floor, wood-work, and furniture—all of which are painted—are thoroughly scrubbed with carbolic acid soap, and then mopped over with a solution of half a pint of carbolic acid (Calvert's No. 4), to one pail of water. From this time until the ward is again

vacated, no portion of it, not even the floor—unless accidentally soiled—is touched with water.

"The nurses wear such clothing only as can be washed. As soon as the inmates of a ward are well enough to take care of themselves or of one another, their nurse is relieved from duty. She now takes a soap bath, puts on an entirely clean suit of clothes, and goes into a ward which has been thoroughly ventilated and cleansed. Before a new batch of patients falls to her care, she has had one week or more of rest. I visit the wards thrice daily, beginning always with the ward last occupied, and with the patient last delivered. Whenever a vaginal examination is needed, it is put off until all the other patients have been seen. The examining finger is then anointed with an ointment containing carbolic acid, and the hands are afterwards washed with carbolic acid soap. Post-mortem examinations I never perform. Whenever one is needed, an expert is called in, and remunerated for his services.

"The beds consist of a tick filled with fresh straw and covered with an army blanket. After the discharge of a patient, her bed is emptied, and the tick, blanket, and bedclothes are boiled in water to which a little carbolic acid has been added. Each bed is furnished with a feather bolster and pillow, which are exposed on slats to the air when not in use. Once a year every bolster and pillow-tick in the house is washed, and the feathers baked and "renovated," as it is technically termed. They also pass through the same process whenever soiled, or whenever used by a patient whose convalescence has been delayed.

"The patients come chiefly from the poorest classes; but many in more comfortable circumstances, with the hope of getting better care, seek admission on account of some difficulty attending their former labours. On this account, the proportion of difficult labours is much above the average. Those patients who have families often put off coming in until labour has actually begun, and then leave at the earliest possible moment. Notwithstanding this, since patients have the privilege of remaining four weeks after their delivery, the average stay of each one is sixteen days before delivery, and eighteen days after. Every patient, upon admission, takes a warm bath, and at least one a week thereafter before her delivery. If she exhibits signs of feeble health, she is at once put upon the use of quinia, and of the house mixture, consisting of two parts of the muriated tincture of iron, with three of diluted phosphoric acid. The habitual constipation of pregnancy is met by the administration, either in the morning of a teaspoonful of pulv. glycyrrhizæ comp. of the Prussian pharmacopœia; or, at bedtime, of four Lady Webster's pills (pil. stomachicæ). When a more active purge is needed, the pulv. jalapæ comp., or the pil. cathartic. comp. (U. S. P.) is given. Headache and sleeplessness are treated by warm baths, by full doses of potassic bromide, and by the above-named medicines, when indicated; albuminuria is dealt with in pretty much the same way, but always with iron and phosphoric acid. The regular diet is plain and wholesome, yet more liberal than is usual in charitable institutions. Apart from the frequent use of aperients, a relaxed condition of the bowels is promoted by serving table syrups at every meal, by fruits—fresh or dried, according to the season—and by all such vegetables as can be eaten raw, viz., lettuce, cress, radishes, leeks, onions, tomatoes, cucumbers, and cabbages. Of these, in this latitude, an ample supply is obtainable during nine months of the year.

"When a patient falls into labour, she first has her bowels moved by an injection, and then takes a warm bath. The bag of waters is usually ruptured artificially, and the liquor amnii collected in a grocer's scoop. The second stage of labour is never allowed to linger; any delay is met by the use, either of the vectis or of the forceps. As soon as possible after the birth and the removal of the child, the placenta is delivered by Crede's method. I may here remark that the still pulsating cord is first cut, then "stripped" of its blood, and as much as possible of its gelatin, and finally tied, when it has ceased to bleed, and has become flaccid. Neither belly-band nor any kind of dressing is afterwards applied, but the cord freely dangles about from the navel. Treated in this manner, it dries up without any bad smell, and falls off like a ripe fruit, without leaving a raw stump. Out of more than five hundred infants treated

thus, not one has had a pouting or sore navel requiring treatment, and not one has had an umbilical hernia. I am also well satisfied that, by dispensing with the belly-band, I have had fewer cases of inguinal hernia. Those of my readers who wish a more detailed account of this method of dealing with the cord, can consult the *American Journal of Obstetrics*, vol. iii. p. 327.

"Ergot is hardly ever resorted to as an oxytocic; but one teaspoonful of the fluid extract is invariably given as soon as the head presses upon the perineum. When the labour is over, the perineum is examined, and, if torn, is at once sewed up with silver sutures. The patient is now washed clean, and a binder and cylindrical compress applied, the latter in the hollow just beyond the fundus of the womb. The bedstead on which she has been delivered is next wheeled from the Delivery Room to a ward and placed along the side of a bed, to which the woman now hitches herself over. Contrary to the generally held opinion that absolute rest after labour is indispensable, in no single instance has this muscular exertion apparently brought about a flooding. It seems rather to condense still further the uterine globe. Very rarely, indeed, has a flooding happened outside of the Delivery Room. However warm the weather, a blanket is thrown over the patient, and a foot warmer put to her feet. These remain until reaction sets in, and she asks to have them removed. A mug of beef-tea made from Liebig's extract is now given, and the child put to the breast as soon as it will take it. Thereafter, in a natural convalescence, the woman gets tea, boiled eggs, bread and butter, for breakfast; potatoes, and some kind of meat for dinner; stewed or fresh fruits, tea, bread and butter, for supper. On the morning following the day of her labour, the binder is removed for good, and she slips into a chair while her bed is making. This is repeated once or twice a day until the fourth or fifth day, when she, if so disposed, gets up and dresses herself. No patient quits her bed against her will; yet the force of example is so great, that very few care to stay in bed, when they see their companions up and about.

"No woman is allowed to suffer from after-pains. Whenever these are complained of, one-quarter grain doses of morphia are administered every hour until relief is obtained. In stubborn cases of after-pains I have found nothing act so promptly as the exhibition of ten grains of quinia every six hours, until the ears ring. For this valuable suggestion I am indebted to my friend Dr. Fordyce Barker. Bed-pans are not employed, except in cases of illness, or in cases requiring vaginal injections; but each woman has her own chamber-pot which she uses indifferently, either in the sitting or the knee-elbow posture. Every woman is required to wash her own person at least once a day, and that with carbolic acid soap and a wad of fine oakum, which is at once thrown away. Only under very exceptional circumstances does the nurse cleanse the patient. Should the lochia become offensive, the woman is made to get out of bed and slip into a chair three or four times a day. This usually corrects the fetor; but if it does not, then and only then is a solution of potassic permanganate thrown up into the vagina. Firmly believing the nozzle of a syringe to be the medium of virus communication from patient to patient, I avoid the use of vaginal injections as much as possible. For a like reason, the temperature thermometer is not habitually used, but only in single cases as an aid to diagnosis.

"Whenever the lochia are offensive, or the pulse is over 90, or the thermometer indicates a temperature higher than natural, or pelvic pains are complained of, or, in short, whenever any untoward symptom appears, quinia is given in from six to ten-grain doses every four hours, until the ears ring. In addition, for abdominal pains large doses of morphia are given, and the whole belly is painted with iodine, and covered with a mush poultice. The canonical purge on the third day is dispensed with. A patient has usually a movement of the bowels either before, or on the day in which she gets up for good. If this does not happen, she takes four Lady Webster's pills at bedtime, which then act on the morning of the sixth day. As soon after getting up as she feels strong enough, she takes a warm bath."

(*To be concluded.*)

### *Obstetrical Anæsthesia.*

Professor Gubler, presenting a memoir to the Académie de Médecine upon this subject from Dr. Campbell, the well-known obstetrician of Paris, drew an observation from Prof. Depaul, which we may notice. The purport of Dr. Campbell's memoir was to give an account of his experience in the administration of chloroform. He has, it seems, employed what he calls "obstetrical anæsthesia" in 942 cases without having to regret the slightest accident; and he believes that the cause of such immunity is to be found in the efforts rendered necessary for the expulsion of the infant and the cerebral hyperæmia which necessarily accompanies these. Prof. Depaul observed that surgeons understand by the term anæsthesia the absolute loss of movement, sensibility, and consciousness, which is determined by the administration of a more or less considerable quantity of chloroform or ether. But in none of Dr. Campbell's cases was this kind of anæsthesia produced. He contented himself by giving very small doses of chloroform, by means of which a certain amount of insensibility was produced; and it would be an error to suppose that these 942 women have been subjected to anæsthesia as generally understood with immunity. Accidents from the obstetrical administration of chloroform are not unknown, and M. Depaul is in possession of cases in which sudden death has been produced by it. He believes that great care is required in its administration, and that in cases of ordinary labour it can be very well dispensed with. Prof. Gubler, in reply, observed that in the immense majority of obstetrical cases there is no necessity to carry the anæsthesia to absolute unconsciousness, it often sufficing to determine a slight insensibility in a nervous or pusillanimous woman to facilitate the process of parturition or to obviate certain inconveniences. Dr. Campbell has sought to produce a variable amount of anæsthesia according to the case, and has almost always found that slight insensibility sufficient to which the name "obstetrical anæsthesia" has been given in order to specify it.

(The mere smallness of the dose will not explain the immunity observed in the administration of chloroform to lying-in women, as it is well known that in many cases of death from chloroform this has ensued upon the inhalation of very small quantities of chloroform. The immunity reported by Dr. Campbell has been met with in the practice of all obstetricians; and we would suggest to Prof. Depaul that he would do a good service by publishing the details of the fatal cases which he says he is in possession of.)—*Med. Times and Gaz.*, July 11, 1874.

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### *Local Treatment of Cystitis in Women.*

Dr. J. Braxton Hicks gives (*Brit. Med. Journ.*, July 11, 1874) the results of his experience in the local treatment of cystitis in which he has great confidence, whilst he reposes but little in internal remedies, except such as are correctives of the state of the urine, when it is acid or alkaline. "If the urine," he says, "enters the bladder overcharged with lithates, then a cautious use of alkalies coupled with opiates will assist; taking care that the alkali be suspended as soon as the urine becomes natural in this respect. Again, should we find it alkaline, it may be advisable to employ some mineral acid for a time, also coupled with an opiate. With regard to an opiate, there is no doubt that this remedy is the most valuable of all internal remedies, partly because it lessens reflex sensitiveness, and thus the bladder is not so frequently hurting itself by its forcible contractions, and partly because it gives relief from pain."

In cases of severe acute cystitis, with much pain and frequent or constant desire to micturate; severe scalding along the urethra during micturition; the bearing down constant and intolerable; irritative fever; urine loaded with mucus, purulent and bloody, the first point to make out, Dr. H. says, "is whether the urine be still acid or have become alkaline. I may here add, that it is seldom acid in a case such as here supposed; but at the early stage it may be, before pus has appeared. Generally, it is very alkaline, and commonly also ammoniacal. Supposing it is alkaline and ammoniacal, then proceed in this way. Take a

catheter—gum-elastic is best, and still better if open at its end instead of the side, as usually made—let it be well greased or oiled and passed gently just into the bladder. Draw off the urine. (The open-ended form is of great advantage in many cases where the mucus is copious and very ropy.) Be careful to enter the bladder the least distance possible, and withdraw the catheter just without the neck when the bladder is on the point of being emptied. This saves the mucous membrane from flapping down on the end. Then, with a syringe, throw up through the catheter warm water slightly acidulated with either nitric, hydrochloric, or acetic acid (vinegar does very well); if nitric or hydrochloric acid, about two drops of the strong to the ounce of warm water. As soon as the patient complains of desire to micturate, allow it to flow away again. More of this acidulated water may be used, till the bladder seems clear of the phosphates and mucus. About half a pint of acidulated water will generally suffice.

"Then inject also through the catheter about one grain of morphia dissolved in about one ounce of water; quickly withdraw the catheter from the urethra, and instruct the patient to retain it as long as possible. It is a very rare instance if this single application do not produce very marked benefit. In the very acute cases, the passing of the catheter requires tenderness and care, because of the great sensitiveness of the urethra and lower bladder. But, if the precaution be taken of not introducing the catheter just within the bladder, much pain is saved. The exact distance can, at the first passage, be marked on the instrument. But to avoid the contact of the catheter with the bladder during the washing out, as much as possible, I always pass the injections into the bladder without entering its cavity. This can be readily accomplished by employing an open-ended catheter; a little extra force on the syringe will drive the fluid past the sphincter. If the injections are to be withdrawn, then the instrument can be made to enter, but only, as above mentioned, so far as may be necessary to allow the fluid to flow.

"This treatment should be repeated twice daily, if the case be very severe, and especially in the case of retention, because of the ammoniacal decomposition of the urine; and, as the urine must be drawn off at least twice a day, there will be no additional distress given by passing the catheter.

"In regard to the frequency, there is one point to be considered, viz., the irritation to the urethra caused by catheterization. Of course, it is undesirable that we should pass the instrument more frequently than needful; yet it is to be also noted that frequent micturition itself causes soreness or abrasion of the urethra; so that, if we succeed by our treatment in mitigating the frequency of urination, we shall compensate for this; and this is in accordance with my experience. By the treatment above described, we do very quickly lessen the frequency, and more than entirely compensate for the irritation of catheterization.

"Where the urine has not become markedly alkaline, we may content ourselves by simply injecting the solution of morphia; yet, if we first of all wash out the bladder with warm water or warm solution of permanganate of potash, we shall much expedite the cure. The strength of the lotion should be three times that generally in use, as it is very rapidly decomposed by the urine. When this has been allowed to flow away, we may inject the morphia solution.

"After some days of this treatment, I sometimes employ, instead of the permanganate of potass, a solution of chlorate of potassa, about three or four grains to the ounce; using plenty, drawing it off after a few minutes, according as it gives pain, and then injecting the morphia.

"Regarding the dose of morphia, I may add that, if there be no blood in the urine and the patient feel no constitutional effects from a grain, I increase it to two grains. If blood appear in the urine, it is a sign of some abrasion, in which case the morphia is more likely to be absorbed; yet I have never seen any unpleasant symptoms even from two grains. The more we use, without affecting the system much, the better; locally subduing the nerve-irritation and the tenesmus of the bladder, and the crushing of the mucous membrane which the contraction produces.

"As the acute symptoms subside, we may employ more astringent washes;

such as two or three grains of tannin in each ounce of warm water, or three or four drops of solution of perchloride of iron, using morphia immediately afterwards, as before mentioned. Our choice depends upon the amount of pain caused, the object being not to cause more than necessary. If the urethra be very tender, and catheterization seem to produce irritation, I omit all treatment for a day or two, after which we can resume it with much benefit. If after a fortnight the main symptoms be subdued, but the urethra seem very tender, I apply an astringent directly to it. A bougie or catheter, covered with tannin, made very smooth, and dipped in gum-water before introduction, is not very painful, and answers well. A probe, on which a film of nitrate of silver has been fused, may be tried. Of course, pain succeeds; but, on its subsidence, patients have expressed much relief. However, in the more acute stages and forms of cystitis, one should avoid this, unless the urethral irritation be very marked. Later on, this may be freely adopted and other remedies tried, as passing a stick of fused anhydrous sulphate of zinc, or even mopping over the urethra with solution of perchloride of iron, carried up by a probe covered with cotton-wool or similar material. This irritation of the urethra is the cause generally, in cases with frequent micturition, of much additional suffering, and, by its reflex action, keeps up the irritation of the bladder; so that we may say they play into each other's hands. The urethra bears active treatment better than the bladder, and I have even dilated it and mopped it over with solution of perchloride of iron, with great relief the next day.

"But, when cystitis has become chronic before we see it, or we have arrived at the same condition, but much earlier, by our treatment, we sometimes find it troublesome to completely cure the complaint. I have found, at this time, the injection of a solution of nitrate of silver of much service—from five to ten grains to the ounce. I have even used it up to fifteen grains to the ounce. This causes some rather severe pain for a short time, but much relief afterwards. Of course, two grains of morphia are left in afterwards. This may be repeated a week later. Or, instead of the nitrate of silver, I have employed perchloride of iron stronger than before mentioned (ten minims to the ounce). Now and then, for a few days together, it is well to leave off treatment in the chronic stage, to see how far the local interference may be rather keeping up irritation. I may be thought rather to be condemning local treatment by thus remarking, but really it is not so; we can, by local treatment, soon make a most distressing malady a bearable one; yet, at the same time, we know that frequent passing of the catheter may cause irritation, but slight only compared with acute severe cystitis. It is only when we come to the end of the case that we have to note the possibility of keeping up a slight irritation by our too frequent action.

"I may add that, in the acute stages, the warm hip-bath, and warm sponge to the genitals, are not to be omitted, together with perfect rest in bed; the bowels must be kept gently relaxed; the dietary should be very simple and light, such as will naturally commend itself to our judgment upon common principles. But on no account should any kind of alcoholic beverage be permitted; and this rule should be observed rigidly during the whole period of the complaint, excepting only in such cases as it is imperatively necessary from other conditions of the patient's health.

"I have thus only rather shortly sketched out the plan which I have used and would strongly recommend to your notice. The benefit of such management is very marked in cases of paralysis, where, from retention or the rapid ammoniacal decomposition of the urine, the distress and constitutional irritation are very distressing; and thus we can often lessen the chance of the extension of the irritation to the kidneys. Again, in malignant disease, the simple injection of acidulated warm water gives amazing comfort, removing the phosphates and ammonia, and, when to this is added the morphia, a wonderful comfort is felt. Indeed, so much relief is obtained, that, with a large calculus in the bladder, its presence is almost enterely unfelt if morphia be daily injected.

"I would recommend the extension of this treatment to inflammation of the male bladder. The same precautions can be taken regarding the entry of the catheter. I have found that it is not needful to pass the end through the

sphincter; but, if an open-ended catheter be employed, the fluid will find its way through readily. If the catheter be only passed about three or four inches, even then the fluid will find its way into the bladder; and this is an advantage for the male, as the area of urethral irritation by catheterization is thereby lessened.

"After cystitis has lasted some time, irritability generally exists for some considerable period afterwards. This is much lessened by occasional morphia injections; but it may very possibly be due to the contracted state of the bladder, which cannot be quite overcome by the will, although the exercise of the power of retaining urine increases the power of the sphincter, and consequently the capacity of the bladder. In this case, we may often succeed with a plan which I have some time ago, and again more recently, advocated, namely, gently distending the bladder with warm water by means of a syringe, which frequently overcomes the difficulty in a few days."

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*Treatment of Fibrous Tumours of the Uterus by the Hypodermic Injection of Ergotine.*

Dr. Lombe Atthill, Obstetric Physician to the Adelaide Hospital, Dublin, reports (*Irish Hospital Gazette*, Sept. 1, 1874) three cases of fibrous tumours treated by this method, which, in the author's opinion, established two facts: 1st. That the hypodermic injection of ergotine is most efficacious in restraining uterine hemorrhage depending on the presence of a fibroid; and, 2dly. That the treatment is not altogether unobjectionable; for in all my cases troublesome abscesses sooner or later formed, and in two of the patients gave rise to considerable disturbance.

Experience has proved to Dr. Atthill the correctness of the observations made by Dr. Keating, of Philadelphia (*American Journal of the Medical Sciences*, July, 1873), that the tendency to inflammation occurring after the injection of ergotine, is much lessened by passing the needle through the cellular tissue into the substance of the muscle.

Dr. Atthill deduces the following conclusions from his cases:—

1. That *Wigger's pure ergotine* is inert, and useless for the purpose of hypodermic injection.

2. That *Bonjean's* ergotine hypodermically injected, exerts a marked effect on cases of uterine fibroids, lessening the amount of blood lost, and lengthening the periods, but that its use is liable to be followed by the formation of abscesses.

3. That the *extractum ergotæ liquidum*, B. P., is still more efficient in checking the uterine hemorrhage occurring in these cases, but that its use causes at the time severe pain, and that troublesome abscesses are very likely to form at the site of the injection.

To me it seems remarkable that in Dr. Hildebrandt's cases, no unpleasant symptoms ever resulted, while in mine, abscesses invariably, sooner or later, occurred. I can only account for this discrepancy in results, by supposing that the ergotine used by Dr. Hildebrandt is different from any I could procure.

If a preparation can be found, at the same time efficient in controlling the hemorrhage, and not liable to produce troublesome sores, a great benefit will be conferred on the unfortunate subjects of that painful, and indeed often fatal affection, fibrous tumours of the uterus.

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*Treatment of Cancer of the Uterus.*

Prof. Karl Schröder (*Sitz. Ber. der Physic. med. Soc. zu Erlangen*, 1873) gives the details of two cases in which he employed with great advantage an alcoholic solution of bromine in the treatment of this disease. The following is the way in which he uses it: Having removed by the écraseur or scissors as much of the diseased mass as is possible, he applies the actual cautery to the stump, pressing it deeply into all those parts where any of the new growth is detected. After the eschar has been detached, having first protected the

healthy parts by applying cotton-wool dipped in a solution of carbonate of soda, he presses against the diseased parts plugs of cotton-wool moistened with an alcoholic solution of bromine (1 in 5). He thinks the bromine attacks the cancerous growth more energetically than the normal tissues.—*Obstetrical Journ. of Great Britain*, March, 1874.

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*On Intrauterine Fibroma of the Orbit.*

At the sitting of the Königsberg Society of Medical Science, on February 9 (*Berliner Klinische Wochenschrift*, July 20), Herr Perls demonstrated, as a contribution to the causation of growths developed in utero, a case of fibroma of the orbit, with infiltrating ostitis of the roof, and a fibromatous thickening of the dura mater. The case occurred in the practice of Herr Loch, of Danzig. The infant was born with marked exophthalmus on the right side, and died within twenty-four hours.

The external upper half of the cavity of the orbit was filled with a rounded smooth solid mass, about two inches in diameter, thicker behind than forward. The periosteum was lost in the mass of the tumour. The external rectus passed over it, separated from it. A transverse section displayed a very hard smooth fibrous surface, chiefly of an opal yellow, in places of grayish-green colour. The lachrymal gland was absent. Under the microscope it presented a hard fibrous structure, with a few cells; chiefly, however, composed of fine fat-molecules and a few vessels. In places there were small bunches of fat-globules. The dura mater exhibited a small round thickened spot, about the size of a sixpence; its upper surface was not smooth, but uneven, and beset with fine proliferations of areolar tissue. When the dura mater was stripped off, it was about two millimètres in thickness, and of a very hard thick fibrous consistence, of a greenish-gray colour on section. The place where the dura mater was attached presented a somewhat crumbling soft irregular surface, and a portion was adherent to it. The under surface, with which the tumour was connected, exhibited a similar condition. The separation from the bones both of the dura mater and tumour was easily effected, and its surface appeared on both sides partly finely and partly coarsely fibrous. The pores were covered and filled up by a soft tissue in most places. The middle portion of the orbital roof was very thin and fragile, and showed several small irregular holes permeating its whole thickness, equally filled up with the soft tissue. This soft tissue presented the small cells and vascularity of a granulation-membrane, and the surfaces of any section showed the bones to be more or less infiltrated with this material, and that principally in the lacunæ (Howship's). On colouring with carmine, the membrane that filled up these lacunæ was found to consist in part of small cells, or large cells containing many nuclei, whose form often exactly corresponded with the depressions in the remaining bone-substance. The structure of the bone everywhere beyond these lacunæ was normal.

Herr Perls remarked on the extreme rarity of any growth occurring during intrauterine life, except dermoid cysts and erectile tumours. He believed this to be an unique preparation. Whether the preparation in the Göttingen Collection of an enormous (osteogenous?) fibroma on the scalp of the child was intrauterine or not, was not evident from the description given by Förster.—*London Med. Record*, Aug. 19, 1874.

## Medical Jurisprudence and Toxicology.

### *Poisoning by Chloral.*

Dr. ANSTIE relates (*Practitioner*, Feb. 4, 1874) a case of chloral-poisoning, which is remarkable not only for the unparalleled large dose, but for some of the symptoms evoked. A medical man began to take chloral in ʒss doses in February, 1873, as a hypnotic. He intermitted it for a while, but in August, 1873, he recommenced its habitual use, and took chloral, *during the day*, from one to three times daily. At this time he was very intolerant of alcohol, which, in the smallest quantity, flushed his face, and caused severe headache. For a considerable period he was in the habit of taking *over half an ounce* of chloral in the twenty-four hours. In the beginning of December he was affected with severe general pains, particularly about the joints. The day before Dr. Anstie saw him he had, by mistake, taken an overdose of chloral—viz., *more than an ounce*. He slept during the day, but not in the night, and had dreadful pains. When seen by Dr. Anstie he appeared as if partially drunk, and suffered temporarily from some leg-weakness and want of co-ordinative power. The treatment adopted (sal ammoniac and extr. cannab. ind.) had little effect. The chloral was, of course, discontinued; and in about a fortnight he was fast recovering his power of natural sleep, and the pains had almost entirely disappeared. For a while he was annoyed with a singular dryness of the skin. The pains were peculiar—they did not run in the course of the nerves like neuralgia, nor exactly in the joints like articular rheumatism; they seemed to encircle the limb immediately above or below a joint.—*Dublin Journ. of Med. Sci.*, August, 1874.

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### *On the Madagascar Ordeal Poison.*

In an account, historical and physiological, of the Madagascar ordeal poison, the Tanghinia Venenifera, Mr. ANDREW DAVIDSON (*Journ. of Anat. and Phys.*, Nov. 1873) gives the following conclusions:—

1. The Tangèna must be classed among the cardiac poisons. It uniformly causes death by arresting the action of the heart.

2. It does not act on the heart through the vagus nerve. When applied to the exposed heart its rapidity of action is remarkable. The fact that it arrests the pulsations of the excised heart of the frog is conclusive proof that its influence, when topically applied, is direct, either on the muscular substance, or the muscular substance *and* cardiac ganglia.

3. There is sufficient reason to believe that the Tangèna acts on the spinal cord, producing paralysis and diminishing reflex action.

4. Voluntary motion is abolished, and the irritability of the motor nerves lessened by the poison. When it acts through the circulation in mammalia, sensation is not remarkably affected; muscular contractility is very much diminished. More exact knowledge of the degree and order in which these various functions are affected, can only be obtained by carefully performed experiments made in Europe, where the more delicate electrical instruments can be had.

5. It is exceedingly fatal to man, in doses of thirty grains of the kernel, if not promptly ejected.

6. It causes a numb, tingling sensation in the part with which it comes into contact, and also throughout the body.

7. It is powerfully emetic and purgative, produces great nausea and debility, paralysis of motion, occasionally delirium, narcotism, and perhaps vertigo.

8. It may be inferred to cause death in man, as in all other animals, by tetanizing the heart.

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## CLINICS.

### CLINICAL LECTURES.

*On Pulmonary Infarctions and Metastatic Abscesses in Diphtheria and in Croup.* By M. BOUCHUT, Physician to the Hôpital des Enfants Malades.

For fifteen years the successive editions of my *Treatises on the Diseases of Children* have contained the description of the pulmonary lesions peculiar to diphtheria, and to croup; a subject which one cannot pay too much attention to in order to appreciate with exactness. These lesions offer very numerous varieties according to the stage of the disease, and if, as frequently happens, it is only seen in its *début*, it is very rare to observe its later consequences. I wish to speak of nodules of pulmonary apoplexies or embolic infarctions of the lung, with their gray degeneration, and conversion into metastatic abscesses. From what I have carefully observed, and from very exact observations made in cases of diphtheria and croup, I am of opinion that death is frequently the result of lobular, embolic pneumonia, of disorganized apoplectic infarctions, and sometimes of abscesses consecutive to these infarctions. The following recent observation taken from my service is an example:—

Josephine B———, æt. three years, was brought to me on the 4th of May last, suffering from croup, in the third stage, characterized by anæsthesia. She had been eight days ill. Before her admission she had had several attacks of suffo-

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cation; her parents had made her vomit three times; she had always been a healthy child. Tracheotomy was at once performed. On the 5th, at my morning visit, I found the child in good spirits; there were no râles in the chest, the vesicular murmur having its normal fulness; no albumen in the urine, and no diarrhœa. She remained in the same state up to the 9th, when I found the child in an agitated condition. The wound had commenced to show signs of phagedena, and the discharges from the canula were fluid, without consistence, and of a dirty gray colour. The vesicular murmur appeared a little rough, but there was no râle, and no souffle. This state lasted two days. The wound assumed a healthy aspect, having been touched with a solution of carbolic acid (1 to 100). On the 12th, at the evening visit, I found the respiration very difficult, the vesicular murmur rougher at the left side and behind; the fever was very high; temp. 104°.6; resp. 80; pulse 160.

13*th*. No change in the stethoscopic signs.

14*th*. A marked improvement; the patient is free from fever, and breathes easily. Temp. 99°.6 F.; resp. 45; pulse 148. An attempt was made to remove the canula, but the child instantly showed signs of suffocation.

15*th*. Same state.

16*th*. More fever; has vomited her food. The wound has bled a little. Dulness posteriorly on the right side. In the evening, some additional sub-crepitant râles were heard on both sides. The left cheek is very red.

17*th*. The same state. In consequence of a slight paralysis of the soft palate, food returned through the nose.

18*th*. The general state is worse. A souffle is audible in the supra- and infra-spinous fossæ of both sides, and numerous sub-crepitant râles at both bases. The face is cyanosed; the left cheek being still red. On the anterior aspect of the left leg, there is a small spot, caused by a subcutaneous infarction. Anorexia, and abundant diarrhœa for the first time; no albuminuria; pulse very frequent, 194, strong, bounding, but regular. This grave state continued, and the child died on the 19th.

*Autopsy*.—Both lungs presented the same lesions, but more marked on the right than on the left side. On the right there was slight serous pleural effusion; the lower lobe was here and there covered with thick false membranes, of a dirty yellow colour, which united the lobes with each other, and formed some adhesions with the costal wall. The lung was heavy, hard, resistant, non-crepitant, marbled with black, and some gray spots surrounded by a red inflammatory zone. The black spots corresponded to some hard nodules placed superficially or deeply in the tissue, and the gray spots corresponded with some fluctuating parts. The black nodules were formed by apoplectic infiltration of the pulmonary tissue in the midst of a red, livid, congested, non-crepitant tissue, and they varied in size from that of a hemp-seed to that of a large pea. Some showed at their centre a grayish point of purulent infiltration. The gray, fluctuating spots formed cavities, which varied in size from a pea to a nut: and these cavities were filled with sanious pus, mixed with a cellular detritus of mortified pulmonary tissue, but without a gangrenous odour. Around these abscesses there was a red zone of pulmonary inflammation of some millimetres in extent. There was but one abscess in the lower lobe, and in the upper we found lobular pneumonia and apoplectic infarctions.

The left lung presented similar lesions. The pleura was covered with a grayish exudation, and the upper and lower lobes were riddled with apoplectic nodules. In the lower lobe, besides these nodules, were also five well-formed metastatic abscesses.

The trachea internally was very red, and presented a deep ulceration below the opening made during life, caused by the pressure of the canula.

The heart presented, on the left side, a very characteristic mitral and aortic endocardial vegetation, and in the cavities an old fibrinous, whitish thrombus, caseous in the ventricles and amber-coloured in the auricle. The border of the valve was red, thickened, projecting, and very granular,

and the sigmoid valves were thickened, and of a deep blackish-red colour. On the arch of the aorta were three red patches, in the midst of which were several whitish spots of atheroma. On the right side also was a thick red pad of endocardial tricuspid vegetation, and a very old ventricular thrombus.

The liver, which was very voluminous, had commenced to undergo the fatty degeneration. There was nothing abnormal in the kidneys and spleen. Under the integument, over the front of the tibia, were three subcutaneous hemorrhages the size of a cherry-stone.

This case does not present any particular bearing on the pathological history of croup. It has, however, an important interest as regards the pulmonary lesions caused by diphtheria. As it goes to confirm the doctrine which I have professed for the last fifteen years, and furnishes a proof of facts still little known by medical men, it has appeared to me useful to publish it.

According to the most usually adopted opinion, diphtheria is looked upon as a primary general disease, like smallpox, due to a primary alteration of the blood; and that there is also a diphtheritic poison, complicating the local lesions, which terminate frequently by lobular pneumonia.

From this case, as I have viewed it, diphtheria is, on the contrary, at first a local disease, complicated by absorption from the wound; and from this absorption springs the general infection, the endocardial vegetations, the endarteritis, the infarctions of the cellular tissue and of the lungs, which are frequently followed by pulmonary abscesses, if the patient lives long enough. Such are the facts and the lesions, but little known, which were observed in the foregoing case. The affirmation of a diphtheritic poison without its demonstration is a mere hypothesis; whilst, if we regard ulceration of the pharynx and of the tonsils with or without false membranes, as the point of departure, and look upon the endocarditis, the cardiac thrombosis, and all the lesions of purulent infection, as products of absorption, we avoid the realms of hypothesis and demonstrate what is in reality the case.

In fact, the lesions of diphtheria are those of septicæmia. We find albuminous nephritis, infarctions of the skin, spleen, and liver, acute leucocythosis, and, lastly, infarctions of the lung, which may go as far as the formation of the so-called metastatic abscesses. They do not differ from the lesions of septicæmia, and in general they have nothing particularly special to diphtheria. How has it happened that these lesions have passed unnoticed up to the present time, and that I have been the first to discover and explain them? Why are they yet so little known by physicians? It is because, in general, subjects are examined with a preconceived idea, and because believing that we know the truth we search no further. This is natural. Necessarily, when chance places some unusual lesion under one's eyes, the attention of the physician is awakened, and he is led to reflect on the nature and origin of that lesion. This it was which occurred to me. Educated in the belief that diphtheria was a primary disease of the blood, and that in croup death resulted from pneumonia, such was what I always saw. I accepted that opinion. But when I saw in this pneumonia particular anatomical characters, such as a lobular form; apoplectic nodules or sanguineous infarctions, the infarctions in a state of gray, fatty degeneration; sometimes metastatic abscess consecutive to these softened infarctions, at other times cutaneous and visceral infarctions, and lastly, endocardial vegetations and cardiac thrombosis, I saw that the doctrine was erroneous. In investigating the subject, with the aid of clinical observation, I perceived that the course of the symptoms in membranous sore-throat (*angine couenneuse*), and in croup, indicated that there was a local period in these diseases, without any general affection, a period in which the lesion was quite superficial: that subsequently general phenomena of septicæmia with phagedena, albuminuria, diverse infarctions, and metastatic abscesses, presented themselves; just as

after an operation or after delivery, a traumatic or puerperal septicæmia manifests itself.

It is upon these observations, which can easily be verified by clinical physicians and pathological anatomists, that my doctrine of diphtheria is based; viz., that it is a disease at first local, which becomes, or does not become, general, according as the sub-diphtheritic exudation permits, or does not permit, of absorption. In this view it resembles malignant pustule, which may or may not become a charbon; or a syphilitic chancre, which remains local, and is cured without leaving any traces, or which is absorbed, becomes indurated, and produces constitutional syphilis.

It is upon this theory that is grafted the German one of capillary embolism. In that theory it is also presumed that diphtheria is at first a local disease, but that in the cases of absorption, capillary embolisms, which, entering the heart by the veins, pass into the lungs and the different parts of the body to form small infarctions and metastatic abscesses, occur in the portions affected, as I was the first to point out. The explanation is perhaps correct, but its exactness has yet to be demonstrated, and it is only a hypothesis. Notwithstanding every explanation, however, the fact remains certain, that diphtheria is a local disease which may become general.

The treatment of diphtheria follows very naturally from this doctrine. If the disease is met with at its *début*, it should be destroyed locally, and absorption prevented; to accomplish this it is necessary to cauterize all the diseased part, and not beyond. If we are called to a case too late, and that the diphtheria has passed beyond the tonsils and engaged the pharynx, it is better to abstain from all cauterization, as it cannot be performed effectually. Then, pharyngeal douches of coal-tar saponiné[1] should be employed, which prevent the production of septicæmia. For the last ten years I have employed no other means at this hospital. These douches are given by means of a hydrocele syringe every hour, day and night; the child opens his mouth and leans forward, with a basin under his chin, and the fluid, forcibly injected, issues without even entering the air passages. The following is the formula for the injection: ℞. Coal-tar saponiné of Lebeuf, ʒiij; water, ʒxv. This mode of administration acts more satisfactorily than injections of carbolized water which I have comparatively employed. With these measures I give, frequently, tartar emetic in contra-stimulating doses—gr. ss in ʒij of some vehicle, in teaspoonfuls every hour—and as much nourishment as it is possible to make the patient take.

Feeding is really the best remedy in diphtheria. If a child does not eat he is lost; a little meat does no harm if it is possible to take it; thick soups—it does not matter of what kind—should be given, also bread and butter, milk, biscuits steeped in wine; and, for drinks, strong wine and water, *au sucrée* with brandy, etc. Wine is a powerful auxiliary in the cure.—*Irish Hospital Gazette*, September 15, 1874, from the *Gazette des Hôpitaux*, No. 68, 1874.

[1] Coal-tar saponiné of Lebeuf is composed of tar oil, 100 parts, and tincture of quillaya saponaria, the Chili soap bark tree, 240 parts.—Ed. I. H. G.

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### HOSPITAL NOTES AND GLEANINGS.

*Acute Interstitial Inflammation of the Kidneys in Scarlet Fever, fatal on the tenth day.*—Dr. Joseph Coates relates (*Brit. Med. Journ.*, Sept. 26) the following case, admitted into the Glasgow Royal Infirmary, which is of considerable importance on several grounds. In the first place, we have here an acute renal complication occurring in scarlet fever, not, however, at the usual date of the nephritis of scarlet fever, but in the course of the fever itself. Secondly, the kind of inflammation is not that usually met with in connection with scarlet fever; we have here a case of interstitial inflammation, whereas it is well known that the parenchymatous or tubal form is that commonly met with. It may be also worthy of remark, in the third place, that this is a case of acute interstitial nephritis, a form of disease whose existence has been doubted by some. In connection with the first of these points, I subjoin a brief his-

tory of the case, and an abstract of the *post-mortem* appearances.

Y. R., aged 20, was admitted into the fever wards of Glasgow Royal Infirmary, under Dr. McLaren, on September 30th, 1871. The patient stated that his illness began five days before admission, with loss of appetite, aching pains all over the body, headache, sore throat, difficulty of swallowing, and sickness without vomiting. A scarlet rash was observed by the patient on the second day of his illness; and, on admission, an abundant eruption was present on the trunk and limbs. The throat was slightly affected, but there was difficulty of swallowing. On the day of admission, the temperature was 101.8 deg. in the axilla. After admission, the patient was exceedingly restless, delirious at night, and only half conscious. The eruption is noted as still present on the abdomen on October 4th, and on that day the temperature was 103.4. He died on October 5th, or five days after admission, being the tenth day of the disease.

A *post-mortem* examination was made about twenty-seven hours after death. Both liver and spleen were considerably enlarged, the liver weighing close on five pounds, and the spleen twenty-one ounces. The mesenteric glands were also enlarged, and red on section, and there was redness of Peyer's patches and enlargement of the solitary follicles in the large intestine. Both kidneys were much enlarged, weighing together twenty-two ounces. They presented to the naked eye very much the appearances of the large white kidney, the cortical substance being very pale and much increased in thickness.

The microscopic characters in this case were quite unequivocal. The enlargement and paleness of the kidney were due to an infiltration of the cortical substance in almost every part by multitudinous round cells. These were packed in between the tubules, separating them, but not to any great extent destroying their epithelium. The cells were about the size of white blood-corpuscles, and had a plump full appearance. A thin transverse section shows the appearance described exceedingly well, especially where the epithelium has dropped out; and such is the number of the round cells, that the section has a very close resemblance to one in my possession, taken from a leucæmic nodule in the kidney, there being a similar close infiltration of the interstices between the tubules. Of course there is the essential difference, that, in the present case, the condition is generally diffused throughout the cortex. The epithelium of the renal tubules was very little changed, perhaps slightly enlarged and granular. The section, it may be remarked, very closely resembles a woodcut in Rindfleisch's *Pathological Histology* (New Sydenham Society translation, Fig. 159, vol. ii. p. 162).

We have here, therefore, an acute interstitial nephritis, generally diffused through both kidneys, occurring in a case of scarlet fever, which proved fatal on the tenth day. I am not aware that any similar case has hitherto been recorded, but, of itself, it certainly demonstrates the existence of an acute interstitial inflammation of the kidneys.

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*Case of Hemiopia, with Hemianæsthesia and Hemiplegia.* (Under the care of Hughlings Jackson, at the Hospital for the Epileptic and Paralyzed.)

It is now well known, thanks to Vulpian and Prevost, and to Humphry, Lockhart Clarke, Broadbent, Russell Reynolds, and others, that from a *grave* lesion (a large and sudden lesion) of the higher divisions of the motor tract (corpus striatum and optic thalamus) there results hemiplegia, in which there is not only paralysis of the face, arm, and leg, but also deviation of the two eyes and frequently of the head. The eyes, head, and face turn *from* the side paralyzed, because muscles of these parts on the side paralyzed can no longer balance those of the non-paralyzed side. The patient has lost power to *look* towards the side paralyzed.

It is interesting to observe that hemiopia occurs in some cases of hemiplegia, and these cases seem to be the "sensory analogues" of the above-mentioned cases in which the two eyes and the head are deviated. In the one (when the eyeballs are deviated) the patient is unable to *look* to the paralyzed side; in the other, when

there is hemiopia, he is unable to see to the paralyzed side. The lateral deviation, with rare exceptions, is a transitory symptom: the hemiopia, Dr. Hughlings Jackson has discovered in a few chronic cases of hemiplegia; possibly it is sometimes transitory. Of course, cases in which the hemiopia has come on at the same time as the hemiplegia—cases of a single lesion—are alone spoken of. When the two symptoms are found after a *sudden* seizure, as in the case to be narrated, we may assume that they are owing to a single local lesion.

Dr. Hughlings Jackson has had no autopsy on any case of this kind. But since he thinks hemiopia in cases of hemiplegia may be overlooked, especially when the lateral fields of vision are not blind but only obscured, it is permissible to draw attention to the clinical association. We should examine the field of vision in all cases of hemiplegia when the patient's condition permits. These examinations will be of very limited value unless we at the same time note the *kind* of hemiplegia. In the few cases of which Dr. Hughlings Jackson has notes there has been considerable defect of sensation in the paralyzed parts—face, arm, and leg. There has been hemianæsthesia as well as hemiplegia. It is true that in *many* cases of hemiplegia there is some defect of sensation *soon after the attack*, but it is rare to find great loss of sensation in a *chronic* case of hemiplegia; the cases of hemiplegia with hemiopia, above spoken of, were chronic. Another thing to be noted is the relative degree of loss of power, in which the several paralyzed parts suffer. In hemiplegia, the rule is that the arm suffers more than the leg; but in some, at any rate, of the cases of hemiplegia with hemiopia, the leg suffers more than the arm—or, rather, suffers more in proportion than is common.

Dr. Hughlings Jackson, having had no autopsy, refers to the tenth of Charcot's Lectures on Diseases of the Nervous System. From that Lecture we take the following: "In short, we may conclude, I think, from what has been said, that there is, in the cerebral hemispheres, a complex region, lesion of which determines hemianæsthesia. We know approximatively the limits of this region; but, actually, the localization cannot be pushed further, and no one has the right to say whether, in the region indicated, it is the optic thalamus which is implicated rather than the 'capsule interne,' the centrum ovale, or the third nucleus of the corpus striatum." In *Le Progrès Médical*, Nov. 1, 1873, is a valuable paper by Bourneville entitled "De l'hémianesthésie liée a une lésion d'un hémisphère du cerveau."

Cases like the one to be now narrated have interest with regard to the elucidation of those remarkable cases of migraine, in which temporary hemiopia and temporary one-sided sensation disorder are symptoms.

*Anæsthesia of the right halves of the two retinæ and corresponding loss of sight in the left fields of vision; hemiplegia of the left side (of the side to which he sees imperfectly); very considerable defect of sensation of that side.*—Thomas R——, aged sixty-five, on November 24th, 1871, at 8 P. M., felt sick, and vomited in the back yard of his house. He then went up stairs, but after three steps he had suddenly to stop, fell against the railing of the stairs, and next became unconscious. He felt as if (with the left foot) he were treading on sponge. He was "unconscious" for two weeks, but whether deeply so all the time is uncertain. He talked in three weeks, but for six weeks he was too ill to be left night or day. We have evidence of a sudden seizure with loss of consciousness, evidence pointing to a "grave" lesion somewhere. The probability is, that that grave lesion is clot, but it is possibly softening from thrombosis of the *trunk* or of a *large branch* of a cerebral artery[1]—a large branch, because the lesion must have been a very "grave" one.

There has been no albuminuria to support the diagnosis of clot. It is clear, at any rate, that there was a sudden and local lesion of the right side of the pa-

[1] The posterior cerebral artery has, according to Duret (*Archives de Physiologie*, Janvier, 1874, p. 81), ten branches, of which one is, in Duret's nomenclature, "Artère interne et postérieure de la couche optique," and another "artère moyenne des tubercles quadrijumeaux." Duret's researches are of great value both for the pathology and physiology of the brain.

tient's brain, and probably the disease is in the hinder part of the optic thalamus. The hemiplegia was discovered when the patient came round from the insensibility, but during the first fortnight it was observed that his left leg and thigh were "as cold as a stone."

March, 1873. — *Examination by* Dr. Hughlings Jackson.—Motor: There is now no paralysis of any part supplied by cranial (motor) nerves, except that there is a very trifling drawing of the face to the right. The eyeballs and the head move well, in extreme movements, in all directions. He can execute all large movements of the upper limb (shoulder on trunk and downwards), but they are all imperfect, feeble, and slow. The leg is more paralyzed than the arm; he can walk, however, a great distance. Sensory: There is great diminution of sensation of the left side of the body, face, trunk, and limbs. This does not follow the distribution of any nerve in particular. The whole of the left half of the head has less feeling than the right, the anæsthesia not being limited to those regions supplied by the fifth nerve. It is to be observed that the defect of sensation does not come *quite up* to the middle line of the trunk; there is about half an inch to the left of the middle line, in which the feeling, if not as good, is nearly as good as on the right. (Probably the sensory nerves of the two halves of the body interlace at the middle line. Herpes zoster occasionally passes the middle line slightly.) When severely pinched with the nails on the trunk or arm he has only an unpleasant sensation, and when he is pinched on the hand he feels it up the arm; "up the marrow of the bones" is his expression. He often drops things out of the left hand —*e. g.*, if he places his stick in it in order to open the garden gate with the right hand, the stick often falls out. He is a tailor. One day, when ironing, he brought the "nose" of the hot iron against his left hand, and yet had only an "unpleasant sensation," although he discovered later that the skin had been severely burnt; the skin was "pushed up" he said. He accounted for this mishap by saying that he could *not see to the left.* The left leg feels to him cold, and he has, since his illness, slept with one "leg" of a pair of drawers on it. I have, at the hospital, a series of balls of the same size and appearance, but varying in weight irregularly from one of which the inside is lead to one of covered cork. He readily arranged these balls with his non-paralyzed arm, but though he can lift each with the partially paralyzed arm, he does not, so he says, know any difference by weight betwixt them. Dr. Tibbits assisted me in investigating the condition of electric sensibility of muscle, but we could arrive at no trustworthy conclusion.

He is a snuff-taker, but has ceased to take snuff up the *left* nostril, as "it is of no use," he does not feel it on that side. Snuff, of course, is an irritant, and is appreciated by common sensation, but his snuff-taking is important, as possibly the habit may have blunted the sense of smell propor. It is only possible to say, from my examinations, that I think his sense of smell proper is diminished. There is, as stated, hemiopia, and this is on the left (*i. e.*, the left fields, the right halves of the two retinæ being affected). This defect of vision he found out when he came round from the insensibility. He occasionally sees only part of a word. He one day saw "land," the real word being "Midland." He remarked to his son that "Liver" was a "queer name," but his son pointed out to him that it was "Oliver." These words were in capitals on carts in the street. I could not come to any conclusion as to taste; if affected on the left side it must be so only slightly. He is said to have been deaf of the right ear thirty-five years, and as to the left, it can only be said that his wife is sure that he does not hear so well as before the illness. He seems to me to hear well on both sides.

1874.—His condition seems to be still practically the same. He has had what was probably a slight paralytic attack early this year, but no clear account of it was obtainable. It left no obvious permanent effects.—*Lancet*, August 20, 1874.

# MEDICAL NEWS.

## DOMESTIC INTELLIGENCE.

*Bromide of Potassium in Malarial Fever.* By Henry J. Hilliard, M.D., of Scottsville, Harrison County, Texas.—I wish to call the attention of the profession to the beneficial effects of the bromide of potassium in malarial fever. I do not think that it is an antidote to the malarial poison, as are cinchona and its salts, but that it is a great auxiliary. For the past two years I have very successfully used it, both in the intermittent and remittent forms. In the majority of cases of malarial fever the nervous phenomena are quite prominent, more especially in children, whose nervous system is so susceptible of derangement. The bromide of potassium, conjoined with the local application of cold water or ice to the head, acts very beneficially in such cases by relieving the delirium and restlessness. I generally give adults, during the stage of exacerbation, the following: ℞. Potassii bromid. ʒj; spiritus nitre dulc. gtt. xv; aquæ puræ, fʒj; repeat every two hours, till the period of defervescence, when quinia should be freely given; at the same time continue the bromide at longer intervals during the remission. A short time after the first dose is given, the patient generally becomes quiet, perspiration commences, and the mouth becomes moist. Cinchonism seems to be much more easily produced, absorption taking place more readily. It has greater effect over infantile convulsion during malarial fever, than anything I have ever used. Should the case be urgent, it is well to combine a full sedative dose of quinia with the first dose of the bromide, even in the stage of pyrexia; quinia being the antidote to the poison. Children seem to tolerate the use of the bromide very well. Give to a child three or four years of age the following: ℞. Potassii bromid. ℈j; spts. nitre dulc. gtt. v; aquæ puræ, fʒss; repeat every half hour or hour, according to the frequency of the convulsions. As before said, quinia should be given in sufficient doses to produce cinchonism as early as possible; the bromide having its greatest effect in controlling the nervous phenomena. Should the taste be objectionable, add some pleasant syrup.

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*Immense Dose of Morphia taken; Recovery.*—Dr. George Wood, of Faribault, Minn., records (*Canada Med. and Surg. Journ.*, October, 1874) a case of a woman who swallowed at a quarter before eleven P.M., forty grains of sulphate of morphia mixed with an ounce of laudanum, and a little cold water, with suicidal intent. Her deep snoring excited the attention of a servant, and Dr. Wood was sent for at half-past eleven o'clock, three-quarters of an hour after the opiate was taken. He found the patient with stupour, quite motionless; pupils contracted almost to a pin's point; breathing laboured; pulse slow and full; skin covered with clammy perspiration. He at once gave her an emetic of pulv. ipecac., oz. js, in combination with extr. stramon. fid. min. xv. Emesis at once took place, and then thoroughly drenched the stomach with enormous quantities of warm water, and gave brandy and coffee very liberally. In addition, the extremities were diligently rubbed, and the patient obliged to make forced marches of several hours' duration round the room. His efforts were happily successful, and the patient is now thoroughly well.

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*Early Maternity.*—Dr. E. A. Goodridge records (*Medical Record*, Oct. 15th, 1874) a case of a coloured girl who was delivered of a female infant when she had arrived at the age of 12 years 8 months and 25 days. She had commenced menstruating soon after her eleventh birthday. Cases of earlier maternity have been recorded.

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*American Public Health Association.*—This Association will convene at Philadelphia, Tuesday, November 10, 1874, in accordance with the adjournment of the annual meeting. The following order of business has been adopted by the Executive Committee.

The meetings will be held at the College of Physicians, corner of Locust and 13th Streets, Philadelphia.

ORDER OF BUSINESS.

*Tuesday noon, November* 10.

1. Registration of members and others in attendance.
2. Introductory Remarks by the President of the Association.
3. A Paper on Excessive Infant Mortality in Cities, and the means of its Prevention. By Prof. HENRY HARTSHORNE, M.D., of Philadelphia, Pa.
4. A Paper upon the Influence of Hereditary Diseases upon the Health of the People, with Suggestions of Methods of Prevention. By J. R. BLACK, M.D., of Ohio.
5. The Health of Tenement Populations, and the Sanitary Wants of their Dwellings. By EDWARD H. JANES, M.D., of New York.
6. A Report upon the Death-rate in Towns of Michigan; and comparison of these with Dr. FARR'S *Life Tables* of Health Districts of England. By H. B. BAKER, M.D., Secretary State Board of Health of Michigan.
7. A Report upon Hospital Construction. By J. S. BILLINGS, M.D., Assistant Surgeon, U. S. Army.
8. A Paper upon Hospital Architecture and the Perfect Ventilation of Hospital Wards. By CARL PFEIFFER, F.A.I.A., of New York.
9. Conference of Sanitary Officers and others upon Methods and Experience in the Public Health Service.

Closing at 6 P. M.

*Discourses: Tuesday Evening.*

First Discourse, by Rev. SAMUEL OSGOOD, D.D.: *The Relations of Health and the Higher Culture.*

Second Discourse, by Hon. L. H. STEINER, M.D., of Maryland: *Health a Prerequisite of National Success in Peace and in War.*

Third Discourse: *The Sanitary Relations of Hospitals, and the Economy of Perfect Care of the Sick and Hurt.*

*Wednesday, November* 11.

1. 9 A. M. Business Meeting and Reception of Voluntary Papers, etc.
2. A Paper upon the Ground in relation to Diseases. By EDWIN M. HUNT, M.D., President of the Sanitary Commission of New Jersey.
3. A Report upon the Deterioration of Vegetables and Fruits, as connected with their Gathering, Transportation, Storage, and Marketing. By S. C. BUSEY, M.D., Washington, D. C.
4. A Report upon the Sanitary Government, Vital Statistics, and the Methods of public Health Administration in the Cities and Large Towns of North America. By E. HARRIS, M.D., of New York.
5. A Paper upon the question—Does Smallpox become Epidemic, or is it spread solely by its own contagious property? By EDWIN SNOW, M.D., Superintendent of Health, Providence, Rhode Island.
6. A Report upon Yellow Fever on the Dry Tortugas. By HARVEY E. BROWN, M.D., Surgeon, U. S. Army.
7. 2 P. M. A Discourse by S. D. GROSS, M.D., LL.D., D.C.L. Oxon., upon *The Factors of Disease and Death after Injuries, Parturition, and Surgical Operations.*

4 P. M. A Conference upon Laws and Methods of the Public Health Service of the different cities and States. By Officers and Members of Boards of Health.

*Discourses: Wednesday Evening.*

First Discourse: By Prof. CHARLES F. CHANDLER, M.D., LL.D.: *Practical Applications of Chemistry in the Public Health Service.*

Second Discourse: By Prof. EDWARD ORTON, President of the Ohio Agricultural College: *Certain Relations of Geology to the Water Supplies of the Country.*

Third Discourse: By Gen. E. L. VIELE, Civil Engineer: *Principles and Practice in Drainage and Sewerage, in connection with Water Supplies.*

*Thursday, November* 12.

9 A. M. Business meeting and Election of Officers and Committees.

1. State Medicine the Basis for the Elevation of the Standard of Medical Education. By STEPHEN SMITH, M.D., of New York.

2. A Paper on Syphilitic Contamination Dyscrasia, with reference to Public Health Interests. By FREDERICK R. STURGIS, M.D., of New York.
3. A Paper upon Sanitary Relations of Pharmacy and Materia Medica. By J. M. MAISCH, Secretary American Pharmaceutical Association.
4. A Paper upon "Hay Fever;" Original Researches with reference to Causation and Prevention. By GEO. M. BEARD, M.D., of New York.
5. A Report upon the Sanitary Status of Colorado. By W. R. WHITEHEAD, M.D., of Denver, Colorado.
6. A Paper by Hon. LORIN BLODGET, of Washington, D. C.
7. Voluntary Reports and Papers.

4 P M. Sanitary Conference upon Laws, Methods, and Experience in Public Health Service.

*Discourses: Thursday Evening.*

First Discourse: By Hon. DORMAN B. EATON, of Washington: *Health Laws and the Interests and Obligations of the State National Governments pertaining thereto.*

Second Discourse: *The Duty and Resources of the National Government in the Encouragement of Public Health Measures and Sanitary Science.*

The foregoing schedule is based upon the offerings which are already promised. Various other contributions are expected.

Voluntary papers and reports, and a preparation of members or other promoters of sanitary science and improvement to join in deliberations upon questions indicated in this schedule, will conduce to the leading object of the meeting; and such co-operation is cordially invited. Opportunity will be offered each day of the session for such voluntary contributions, and for a participation in some portion of the afternoon meetings.

*Executive Committee.—President*, Stephen Smith, M.D., New York; *First Vice-President*, Edwin M. Snow, M.D., Rhode Island; *Second Vice-President*, C. B. White, M.D., Louisiana; *Secretary*, Elisha Harris, M.D., New York; *Treasurer*, John H. Rauch, M.D., Illinois; S. O. Vanderpool, M.D., N. Y.; Edward Jarvis, M.D. Mass.; J. M. Toner, M.D., D. C.; Moreau Morris, M.D., N. Y.; J. J. Woodward, M.D., U. S. A.; A. N. Bell, M.D., N. Y.

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*University of Pennsylvania.*—The general introductory to the 109th annual course of lectures was delivered before a large audience by Dr. ALFRED STILLÉ, in the new medical hall just erected on the University grounds, at the corner of Thirty-sixth and Locust Streets, West Philadelphia, and adjoining the University Hospital.

The new hall is spacious, light, and airy, and in its numerous rooms and laboratories affords complete facilities for teaching medicine according to the most approved methods.

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*The Gynæcological Hospital.*—This recent addition to the numerous charities of Philadelphia has been established at No. 1624 Poplar Street, for the gratuitous treatment of the diseases peculiar to women. An infirmary for children has been connected with it, in order to afford to mothers the comfort of knowing that their sick children may be cared for at the same place.

John J. Reese, M.D., Jos. A. McFarran, M.D., and Theodore H. Seyfert, M.D., constitute the Medical Board.

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*State Hospital for the Insane at Warren, Pennsylvania.*—The corner-stone of this Hospital was laid on the 10th of September last. The commission have selected an excellent site. The grounds comprise 200 acres, which were purchased for the moderate sum of $17,000.

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*Curious Literary Coincidence.*—Dr. MIDDLETON MICHEL, Prof. Physiology in the Medical College of the State of South Carolina, calls our attention to the following example of this: In the *Half-Yearly Abstract* (July–Dec. 1873) there is a notice of a paper by Prof. [M.] Michel, of Nancy, published in the *Gazette Hebdomadaire*, No. 35, 1873, on the Linear Extraction of Cataract. Prof. Middleton Michel, of Charleston, read a paper on the same subject before the South Carolina Medical Association in April, 1871, and which

was published in their *Transactions* for that year. Here, then, are two papers on the same subject by authors of the same name, both Professors, and the conclusions of both similar. The Charleston Professor's paper was, however, published two years before that of his *confrère* of the same name.

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*Archives of Dermatology.*—We have on our table the first number (for October, 1874) of this quarterly journal of Skin and Venereal Diseases, edited by L. Duncan Bulkley, M.D. We are pleased to say that it is well filled with interesting articles, and its typographical appearance is excellent. We wish it the success we are sure it will merit.

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*Mr. Erichsen.*—Mr. John Eric Erichsen, the distinguished London surgeon, and author of the *Science and Art of Surgery*, has just paid a short visit to this country, and during the past month visited the principal northern cities of the Union.

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*Promotion.*—Dr. EdwardWarren, formerly Professor of Surgery in the College of Physicians and Surgeons of Baltimore, and who has been for about two years in the service of the Khedive of Egypt, has been promoted to the position of Chief Surgeon of the Egyptian army.

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Obituary Record.—Died after a brief illness, on the 23d of July last, in the 65th year of his age, Dr. Francis Stribling, Superintendent of the Western Lunatic Asylum of Virginia—a position he occupied for thirty-four years, with credit to himself and advantage to the institution.

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## FOREIGN INTELLIGENCE.

*Secondary Traumatic Neuralgia.*—At one of the meetings of the Medical Section of the French Association, recently held at Lille, M. Verneuil drew attention to a complication sometimes met with in wounds, which, without being very serious in its nature, yet is the cause of much suffering to the patient and capable of delaying the process of healing. It consists in more or less severe pains felt in the wound itself and its vicinity, sometimes extending to a great distance, coming on a few days after the injury, and assuming an intermittent neuralgic character. They resist antiphlogistic and narcotic treatment, and yield readily to quinia. The pains usually come on suddenly without obvious cause, and once developed they may become continuous or remittent, but usually take on the form of quotidian intermittent. Concurrently with these, there may be sometimes observed contractions or a kind of powerlessness of the muscles, generally confined to the segments which are nearest the wound; as also vascular disturbances, which seem closely connected with the existence of the local pain, and which sometimes lead to the production of secondary hemorrhage. The surface of the wound sometimes retains its normal character, sometimes presents a diphtheroid aspect, and at others is the seat of phlegmonous inflammation. These changes are dependent on the neuralgia, as they very rapidly yield after the administration of the quinia. The details of the cases observed throw no light on the pathological character of any local changes that may have taken place, but they show that the production of this neuralgia is in intimate connection with the prior state of health and diathesic and moral conditions of those who become subject to it. The appreciation of these readily leads to its diagnosis and successful treatment.—*Med. Times and Gaz.*, October 3, 1874.

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*Successful Treatment of a Case of Traumatic Tetanus by Chloral Hydrate and Bromide of Potassium.*—Dr. J. Carruthers relates (*Lancet*, Sept. 26, 1874) a case of this, in a boy æt. 14. The tetanic spasms came on on the 26th April. Ten grains of chloral hydrate with twenty grains of bromide of potassium in syrup and water, were given every three hours, and on the next day, every two hours. The most marked amelioration of the symptoms was manifested on the third day after taking the chloral and bromide. The patient took 1140 grains of chloral in sixteen days, with the result of the spasms leaving

him in eighteen days from the date of the seizure. The peculiar action of the medicine showed itself in various ways. All kinds of delusions ensued.

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*Pathology of Jaundice.*—*Le Progrès Médical*, reporting the proceedings of the Biological Society of Paris (July 14, 1874), gives the following abstract of M. Raymond's paper. M. Raymond stated that he had observed an interesting fact throwing light on the pathology of jaundice, in two phthisical patients under the charge of M. Vulpian. In his pathological course, M. Vulpian, wishing to elucidate the various methods in which jaundice originates by means of experiments, remarked that, next to obstruction by biliary calculi, the most common form of jaundice is that produced by swelling of the mucous membrane of the biliary passages, the so-called catarrhal jaundice; also that Broussais believed in an extension of the inflammatory process, in what he called gastro-duodenitis. However, his theory was not popular, and it became the fashion to attribute the jaundice to hepatic congestion; but Virchow confirmed Broussais, showing that the obstruction in these cases was caused by a plug of mucus very near the duodenal opening of the common bile-duct. M. Vulpian added, "I have twice seen this in men, and have very often verified it in the dogs on which I experiment." This propagation of duodenitis to the biliary passages is very common in dogs, and it often happens that a number of symptoms are set up, like those collectively known under the name of black or malignant jaundice (*ictère grave*); the dog dies with hemorrhage and ataxo-adynamic symptoms.—*Lond. Med. Record*, Sept. 30, 1874.

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*Severe Nervous Symptoms from Ascarides.*—Dr. J. Lockhart Clarke reports (*British Med. Journ.*, Sept. 19, 1874) the following instructive case. A widow lady, aged thirty-four, had been suffering some months from nervous symptoms of a very distressing character. She was frequently affected for a variable period with complete hemiopia, and sometimes she saw what appeared to be thousands of glittering bits of broken glass before her eyes. The right orbicularis palpebrarum was constantly thrown into such rapid and violent spasm, that she was quite unable to keep the eye open. On further inquiry, it was found that she was very much teased by an abundance of ascarides and by distressing pruritis. In other respects, she seemed to be tolerably well. She was ordered four grains of calomel at night, and an enema of turpentine in gruel in the morning. A large mass of ascarides was brought away; and this was followed by speedy relief of all her symptoms. These, however, returned after a few months, but were again removed by the same treatment.

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*Phosphoric Acid in Urine in Cases of Diseases of the Encephalon.*—Dr. E. Mendel has made a series of experiments on the above (*Archiv für Psychiatrie*), and has arrived at the following results: The quantity of phosphoric acid excreted by the kidneys under the influence of brain disease, and compared proportionally to the other solid principles of urine, varies considerably, from 2.49 to 3.93 per cent. The substance is excreted in greater quantity at night than during the day. In the chronic maladies of the encephalon there is a decrease in the absolute quantity of phosphoric acid excreted every day, as well as of the relative quantity in connection with the other solid principles of urine. In cases of maniacal excitement there is an increase in the absolute and relative quantity of the substance. Increase in the quantity is also observed during attacks of epilepsy and apoplexy, and after the administration of chloral and bromide of potassium. The decrease of the substance in chronic cases of brain disease must be attributed generally to diminution of muscular activity, dependent on the protracted course of the disease. In other cases it may be ascribed to the general weakness and exhaustion of the nervous system, the result of imperfect assimilation.—*Lancet*, Sept. 26, 1874.

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*Stammering.*—The treatment of this defect is now carried on with much success

in France by M. Chervin. His method has been the subject of a favourable report to the Academy of Medicine, in which we find a sketch of the system. The training begins by a respiratory practice, in which the patient learns to steady his voice whilst regulating the respiratory rhythm. Then follows the practice of vowels, which, in fact, constitutes the gymnastics of articular phonation. Lastly comes the demonstration of the functions which the tongue and lips have to perform, and of the shape which the mouth should assume in the pronunciation of each letter of the alphabet. This concludes the initiatory practice. Afterwards we have the combination of letters, vowels, and consonants in the different and respective positions which they may occupy; and, finally, words and periods, with the intonation and expression which they require. The whole consists in gymnastically educating the organs of speech, the excellent results being due not so much to actual muscular work as to the precision with which the practice is carried out. The success depends on an effort of the will on the part of the patient to reproduce with the utmost precision a particular movement. The will of the teacher must take the place of the patient's will, as the latter is unable to regulate the movements dictated by it.

M. Chervin justly remarks that stammering is a kind of chorea of the muscles of respiration and phonation. To remedy this he advises slow and measured gymnastic exercises of respiration, this being the first part of the treatment. It is shown above that he combats the unruly movements of the tongue and lips by subjecting these organs to muscular exercise. This method seems thus perfectly rational, and the government have been advised by the Academy of Medicine to give M. Chervin pecuniary support.—*Lancet*, Sept. 26, 1874.

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*Sanitary Precautions in the Drainage of Houses.*—There are, we may say, four general laws concerning the drainage of houses, etc., which are never transgressed without a corresponding infliction of evil, and as they are so few in number it will be as well to enumerate them previous to enlarging upon each. They are as follows:—

I. Whatever pattern of drain-pipes be chosen, they should be properly laid, and in such a manner as to remove the waste with all possible speed to the sewer or cesspool. The drain-pipes too, should, as much as possible, run outside the house, and should not extend their ramifications inside, as is often the case.

II. Proper means should be taken to disconnect the house-drain from the sewer or cesspool, and when necessary deodorization or disinfection—which should be convertible terms—should be resorted to.

III. Only the most suitable kinds of drains should be used, and pipe-drains in preference to built-up drains.

IV. Trapping should, as much as possible, be rendered unnecessary.—*Sanitary Record*, Sept. 19, 1874.

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*Fruit Kernels Poisonous.*—The following case, which is reported in the *Australian Medical Journal*, calls attention to a source of danger which is often overlooked, viz., that the kernels of some stone-fruits (peaches, perhaps, more than any others) contain the material for the formation of hydrocyanic acid to a great extent, and may, if eaten in any quantity, produce very serious effects. The case is reported by Dr. W. R. G. Samuels, of Wanganui, New Zealand. He says:—

"I was sent for to attend a little boy aged five years, the son of a carpenter of this town. On my way I was informed that the little fellow had eaten something unknown to his parents, and was believed to have been poisoned. On my arrival, I found him lying on the sofa in a state of partial coma. The pupils were dilated, the skin somewhat cold and clammy, the pulse feeble. He seemed, in short, to be suffering from the effects of some narcotic poison. Upon making inquiries, I was informed that, about half an hour previous to my arrival, he had been seized with dizziness, stupor, fainting, inability to stand without assistance; in fact, it was described to me as partial intoxication. He vomited one ounce or more of masticated peach-kernels. I at once ad-

ministered an emetic, followed shortly by a full dose of castor oil, which soon acted on the bowels. I ordered him to be kept warm. After being placed in bed, he slept for about two hours, after which he awoke and seemed recovered. This was obviously a case of poisoning by hydrocyanic acid contained in the peach-kernels, of which the child had eaten a large quantity."—*British Med. Journ.*, Sept. 19, 1874.

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*The University of Vienna.*—In the academical year just ended, the total number of students in the University of Vienna was 7526. The numbers in the Faculty of Law were the largest, being 1619 in the winter, and 1571 in the summer; next came the Faculty of Medicine, with 1109 in the winter, and 1036 in the summer. In the winter there were 891 students of Philosophy and Pharmacy, and 822 in the summer; and the Theological Faculty numbered 194 in the winter and 184 in the summer session. There were 194 new students of medicine, and 228 left the University. At the examinations, 140 medical candidates were approved, and 13 rejected. Degrees were conferred as follows: Doctors in general medical practice, 137; of surgery, 33; of medicine (according to the old regulations), 20. Diplomas of Master were granted as follows: Pharmacy, 54; midwifery, 35; dentistry, 3; ophthalmic surgery, 2; 114 midwives also received diplomas. The records of the numbers attending the classes show that, in the Faculty of Medicine, Professor Brücke had a class of 885; Hyrtl (winter only), 680; Langer, 555; Bamberger, 540; Bilroth, 509; Dumreicher, 495; Duchek, 389; Rokitansky, 354; Karl Braun, 225; Arlt, 218; Vogel, 157, Späth, 126; Sigmund, 94; Meynert, 70.—*Brit. Med. Journ.*, Aug. 29, 1874.

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*University of Edinburgh.*—Dr. William Rutherford, Professor of Physiology in King's College, London, has been elected to the chair of Physiology in the University of Edinburgh, recently vacated by Prof. Hughes Bennett. The appointment is regarded as an excellent one.

*Poor-Law Guardians* seem to possess a wonderful faculty for making themselves contemptible and ridiculous. Ophthalmia has for some time past prevailed at the Mitcham schools, and the attempts that have been made to eradicate the disease have been hitherto futile, notwithstanding some strict orders issued by the local government board to promote cleanliness among the children at the schools. Meanwhile Dr. Bridges, one of the inspectors of the department, has recommended to the guardians of the Holborn Union the adoption of certain measures to stamp out the disease. It was during a debate on these proposals that one of the guardians particularly distinguished himself by his contempt for medical doctrines and by the eccentricity of his desires. He did not care for the suggestions of any medical man; he had an opinion of his own. Much money had been expended in vain attempts to get rid of the disease. The precaution had been taken to supply each child with a clean towel whenever it washed; could any of his fellow-guardians boast of a similar luxury? Could he be born again he would be a pauper child, and enjoy the supreme luxuries in which pauper children now revelled.—*Lancet*, Sept. 26, 1874.

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*Disarticulation at the Hip-joint for Osteo-Sarcoma of the Femur.*—M. Martinet reported to the Anatomical Society of Paris (May 15, 1874), the case of a youth æt. 19, who was admitted into the Hôpital Neckar, under the care of M. Guyon. Wishing to avoid as far as possible the danger of a relapse, Mr. G. disarticulated the femur at the hip-joint on the 11th of May. The wound healed well, the patient made a good recovery, and was well six weeks after the operation. [There must be some error in the dates in the report of this case; at all events it would be premature to pronounce the patient secure from a recurrence of the disease.]

—

*Immediate Occlusion of Gunshot Wounds.*—Dr. Cabasse speaks (*La Tribune Médicale*, Oct. 4, 1874) very favourably of the plan adopted by American military sur-

geons of freshening the borders of gunshot wounds, and then closing them at once with a metallic suture. He reports three cases in which he resorted to it with favourable results, and in twelve others he also employed it, but they were transferred to other hospitals, and he does not know the result.

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*Resemblance of Twins.*—Dr. Bird declares that, according to his own experience during thirty years, twins which are contained in the same membranes, and have a single placenta, resemble each other; while those which are contained in separate membranes and have different placentæ, do not resemble each other more than other children of the same parents.—*La Tribune Médicale*, Oct. 4, 1874, from *Gazette Obstet.*

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*Beneficial Effects of Vaccination.*—The Registrar-General for Scotland, in his last annual report, makes some observations on vaccination which are important. The beneficial efficacy of vaccination he attests by some striking statistics. He says:—

"Before the introduction of vaccination into Scotland, from 12 to 14 per cent. of the total deaths were annually caused by smallpox, while nearly 2 per cent. of those who survived its ravages lost their eyesight, and a very large proportion had their countenances disfigured for life. Since vaccination was introduced into Scotland in 1799, the average annual death-rate from smallpox up to the present day has been only 1½ per cent. of the total deaths, and even that number has chiefly been caused by the deaths of persons who never had been vaccinated. This single fact proves of itself, more convincingly than any arguments, the saving of human life which the general adoption of vaccination has effected."—*Med. Times and Gaz.*, June 6, 1874.

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*Ovariotomy in a Girl Eight Years Old.*—A case of this is recorded (*Brit. Med. Journ.*, March 14, 1874) by T. Spencer Wells. The operation was successful. In the No. of the *Am. Journ. Med. Sci.* for Jan. 1872, will be found a notice of a case of ovariotomy successfully performed in a child only six years and eight months old.

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Obituary Record.—Died in Dublin on the 21st of September last, at the mature age of eighty-four years, Arthur Jacob, M.D., one of the most illustrious representatives of the School of Medicine in Ireland. Dr. Jacob is well known, wherever medicine is cultivated, by the additions he made to the science, and the high positions he has ably filled. He first described the membrane of the eye named after him (membrana Jacobi), and a peculiar ulcer of the lid, also named after him. He was one of the originators and editor of the *Dublin Medical Press*, a spirited weekly journal of medical science; and contributed to it and various other publications many valuable papers. He successively filled the position of Demonstrator of Anatomy at Trinity College, Professor in the Park Street School of Medicine, Professor of Anatomy in the Royal College of Surgeons, etc. etc. In many ways his profession testified their esteem for him; he was thrice elected president of his college; a medal bearing his likeness was struck and presented to him, and his portrait and bust are placed in the Royal College of Surgeons of Ireland. At the age of seventy-nine, in a green old age, Dr. J. retired from the active pursuits of his profession.

——— In London, on the 12th of September, in the forty-first year of his age, Francis Edmund Anstie, Physician to the Westminster Hospital, and Editor of the *Practitioner*. Dr. Anstie is well known to the profession through his valuable contributions to medical literature on Neuralgia, Stimulants and Narcotics, Notes on Epidemics, etc. His death was caused by a dissecting wound received September 6th, during the examination of the abdomen of a child dead from peritonitis.

——— at Filey, Oct. 4, 1874, æt. 83, Joseph Swan, F.R.S., the Senior Fellow of the Royal College of Surgeons. Mr. Swan devoted much attention to the anatomy, physiology, and surgery of the nervous system, and published many valuable memoirs on these subjects.

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For more than two years this work has been out of print, and the author regrets that circumstances beyond his control prevented the publication of a fourth edition of it at an earlier day. He trusts that the delay will have tended to render the present issue worthy of even greater favor than the previous ones enjoyed. It has given him time for a careful revision of the whole work, and the addition of about two hundred and fifty pages of new matter. Several new articles have been introduced, the chapter on Electricity has been almost entirely rewritten by Dr. Matthew J. Grier, and the nomenclature throughout been made to conform to the last edition of the Pharmacopœia.

PHILADELPHIA, Oct. 1874.

From Prof. E. V. STODDARD, *Univ. of Buffalo.*

I have carefully examined this work, and note with satisfaction the additions to the previous editions, making this last issue still more complete. I consider it the most perfect work on the subject in the English language. Aside from its very careful and conservative treatment of the therapeutic properties and use of remedies, its character as a work of extensive research and scholarly attainments renders it peculiarly acceptable. I recommend it more heartily than ever, if possible, to our students, and note with pleasure its very favorable reception by the profession.

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## MEDICAL NEWS.

### DOMESTIC INTELLIGENCE.

*The American Public Health Association.*—This most useful and active association held its annual meeting this year in Philadelphia, Nov. 10, in the Hall of the College of Physicians, Dr. STEPHEN SMITH, the President, occupying the chair. The session was opened by an excellent address by the presiding officer, in which he gave an encouraging account of the progress of the society, though the organization of sanitary associations in this country has not been, he said, very satisfactory.

Dr. HENRY HARTSHORNE, of Philadelphia, followed, with a paper on "Infantile Mortality in Cities," and pointed to some of the causes of this mortality. He claimed for Philadelphia the distinction of being one of the most healthy of cities, owing to the plan of its construction, the number and character of its commodious homes. He adverted to the importance of pure air, and pointed out the errors made in the feeding of infants.

Dr. J. R. BLACK, of Ohio, read a paper "On the Influence of Hereditary Defects upon the Public Health, with Suggestions for their Prevention and Eradication."

Dr. E. H. JANES, of New York, sent a paper, which was read by the Secretary, on "The Health of Tenement Populations and the Sanitary Requirements of their Dwellings," in which he pointed out the main causes of sickness to be, foul air, want of ventilation, proximity to cesspools, etc. etc.

During the *afternoon* session Dr. H. B. BAKER, Secretary of the State Board of Health of Michigan, read a paper on "the Death-rate of each Sex in that State in comparison with Dr. Farr's Life Tables of the Healthy Districts of England."

Dr. J. S. BILLINGS, U. S. A., read a paper "On Hospital Location and Construction;" Dr. WM. PEPPER, of Philadelphia, one on "The Sanitary Relations

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of Hospitals;" Mr. Carl Pfeiffer one "On Hospital Architecture and the Perfect Ventilation of Hospital Wards;" and Prof. John L. Le Conte one "On the Organization of Municipal Boards of Health."

During the *evening* session addresses were delivered by the Rev. Samuel Osgood, of New York, "On the Relations of Health to the Higher Culture;" and by Prof. S. D. Gross, of Philadelphia, on the "Factors of Disease and Death after Injuries, Parturition, and Surgical Operations."

*Nov.* 11. At the *morning* session a paper was read by Dr. Ezra M. Hunt, President of the Sanitary Commission of New Jerssy, "On Building Ground in its Relations to Health and Disease," in which he pointed out the imperfect systems of drainage "resulting in the saturation of the soil with sewage."

Dr. I. Ray, of Philadelphia, spoke of the imperfect construction of the sewers in Philadelphia, which allowed their liquid contents to percolate into the soil, and might account for a great deal of our mortality.

Dr. S. C. Busey, of Washington, read a paper "On the Transportation and Sale of Fresh Fruits and of Vegetables."

At the *afternoon* session Dr. E. Harris, of New York, presented a report upon "The Sanitary Government, Vital Statistics, and Methods of Public Health administered in the Cities and large Towns of North America."

Dr. J. M. Toner, of Washington, D. C., read a paper "On Some Conditions and Accidents which Endanger, Limit, or Prevent Vaccination from giving Full Protection against Smallpox," in which he expressed the opinion that much of the failure was owing to the too sparing use of vaccine lymph by the operator.

Dr. Snow, of Providence, then read a paper in which he discussed the question "Does Smallpox become Epidemic, or is it Spread by its own Contagious Property?" He advocated the latter view.

Dr. Kirkbride made a few remarks upon the proper construction of hospitals. He did not favour the very prevalent idea that temporary structures were most desirable. He believed the best buildings, best heating apparatus, best system of ventilation, and best superintendence that could be secured, were cheapest and most successful in the end.

Dr. J. M. Woodworth read a paper upon "Hospital Construction," in which he advocated the pavilion plan with large wards. Dr. Ashhurst, of Philadelphia, in some remarks, supported Dr. Kirkbride's views. He preferred the construction of permanent buildings, the administration of such being much easier and more economical, while one-story wards were impracticable in large cities.

Dr. C. F. Rodenstein, of New York, read some notes on the causation of scarlatina.

Dr. Benjamin C. Miller, Sanitary Superintendent, Chicago, read extracts from a report upon the methods of treatment of gases from rendering tanks, and the disposal of tank offal, illustrating his subject by drawings.

The Secretary read a portion of a paper prepared by Dr. Harvey E. Brown, on "The Yellow Fever on the Dry Tortugas."

At the *evening* session Gen. E. L. Viele, Civil Engineer, of New York, read a paper "On the Principles and Practice of Drainage and Sewerage in Connection with Water Supplies." He pointed out the marked distinction between drainage and sewerage. In building a city the streets should be laid out in conformity to the topography of the country, and the drainage should be made to flow in the same channels which nature had provided. Any other course was fraught with great danger to the public health.

The problem what to do with the great amount of sewage matter was still unsolved. The subject was but little understood. Putrescent matter was allowed to fill up basins and infect whole neighbourhoods by its noxious exhalations.

Prof. Edward Orton, President of the Ohio Agricultural College, followed in a paper on "Certain Relations of Geology to the Water Supplies of the Country," in which he showed how wells in the city, and often in the country, are contaminated and made unfit for human use.

*Nov.* 12. The *morning* session was

opened by the presentation by Dr. Baker, of Detroit, of a book of samples of wall papers containing dangerous quantities of arsenic.

Dr. Stephen Smith, of New York, read a paper upon "The Reciprocal Relations of the Public Health Service and the highest Qualifications of the Medical Profession."

Dr. Frederick R. Sturgis, of New York, read a paper upon "The Relations of Syphilis to the Public Health." The conclusions which he has arrived at, after extensive investigation, are that the disease is wide-spread and possibly increasing; that it is rarely fatal when acquired, but that there is an excessive mortality in congenital cases, the disease not being transmitted to any great extent to the third generation.

Dr. Geo. M. Beard, of New York, read a paper on "Hay Fever."

A paper was read by Dr. John C. Peters, of New York, "On the Stealthy Introduction and spread of Infectious Diseases in large Cities;" and one by Dr. A. M. Hamilton, of the same city, "On Suicide," was presented but not read.

*Afternoon* session. The first paper read was upon "The Influence of High Altitudes and Climate in the Table-land of the Rocky Mountain Country upon Health and Diseases," by Dr. B. E. Fryer, U.S A. From the experience of the writer, and the statistics of the medical bureau of the army, it appears that zymotic diseases are so rare in these regions as to be almost unknown; pneumonia and other pulmonary diseases, however, are not uncommon.

Dr. J. S. Billings, U. S. A., followed with some extracts from special reports by army officers, in confirmation of the statements made in Dr. Fryer's paper.

Dr. A. N. Bell, of Brooklyn, read a paper "On Certain Perils of the School-room which demand the Attention of Educational and Sanitary Authorities." Light, Air, and Temperature in sufficient quantity and purity were requisites which School-houses as at present constructed did not possess.

He had visited one of the Philadelphia night schools, and found the atmosphere very repulsive. On visiting the cellar, the smell was disgusting, and that portion of the building seemed never to have been cleaned since the floors were laid. Every pupil and teacher in this school was exposed to disease from this source. The depressing effect of impure air upon the children renders them more susceptible to climatic changes, and more likely to become infected with contagious diseases. The great increase of such diseases immediately after the opening of the public schools was too marked to escape the attention of practitioners.

Dr. D. F. Lincoln, of Boston, Secretary of the Department of Health of the Social Science Association, presented a statement of a plan for examining into the state of the health of schools which the department is now engaged in carrying out. The subject of school hygienics has been subdivided into thirteen topics, upon each of which a special report will be made.

At the *evening* session an address was delivered by Hon. Dorman B. Eaton, of Washington, on the subject of "Health Laws, and the Interests and Obligations of the State and National Governments pertaining to them.

A paper was then read by Dr. L. H. Steiner, of Maryland, "On Health a Prerequisite of National Success in Peace and War."

*Nov.* 13. A large number of candidates for membership were elected; and Baltimore was selected for the next place of meeting.

Committees were appointed to investigate and report upon the question to what extent poisons are used in an unsafe manner for agricultural and other purposes, and to recommend suitable regulations and restrictions in regard to the same. Also to prepare schedules for the purpose of collecting information in regard to the present condition of public hygiene in the larger towns and cities of the United States.

The annual election of officers was held, and the following chosen:—

President—Joseph M. Toner, M D., Washington, D. C.

First Vice-President—Edwin M. Snow, M.D., Rhode Island.

Second Vice-President—Prof. Henry Hartshorne, M.D., Philadelphia.

Treasurer—John H. Rauch, M.D., Chicago.

Executive Committee—J. S. Billings, M.D., United States Army, of Washington; Moreau Morris, M.D., New York city; Stephen Smith, M.D., New York city; J. J. Woodward, M.D., United States Army, Washington; J. S. Steuart, M.D., of Baltimore, Md., and A. N. Bell, M.D., Brooklyn.

A special committee was appointed on sanitary legislation.

Prof. J. M. Maisch, of Philadelphia, Secretary Amer. Pharm. Association, read a paper on "American Pharmacy, and its Sanitary Relations."

Prof. S. D. Gross offered a series of resolutions in favour of the establishment of a National Sanitary Bureau, which, after discussion, were referred to the special committee on legislation.

Dr. Henry Hartshorne, of Philadelphia, introduced the following resolutions relative to the establishment of abattoirs in large cities:—

*Resolved*, That for a city, properly arranged and conducted abattoirs, subject to municipal regulations, are preferable to a number of private slaughter-houses located in different parts of a city.

That the best practicable management of large abattoirs, with cattle and hog yards, cannot be depended upon at all times to prevent their drainage from contaminating water and the atmosphere in their vicinity.

Therefore such establishments should be located as far as practicable from the centres of population, and, if possible, upon tide-water.

After presenting these resolutions, Dr. Hartshorne propounded several questions to Dr. Rauch, of Chicago, who, as health officer of that city, has made himself familiar with the subject. These, with his replies, are as follows:—

*First.* Can the disposal and utilization of refuse be made invariably perfect (as a matter of experience) as regards water and air?

*A.* No. Occasionally atmospheric conditions obtain, especially at night, when it is impossible to conduct, as far as my experience goes, the disposal and utilization of refuse without offence. This is sometimes observed near the establishment, and sometimes remote. Generally speaking, however, under favourable atmospheric conditions, these processes can be carried on without being offensive or injurious to health, provided the scientific appliances for rendering, drying, and the disposition of the gases arising therefrom are strictly and carefully maintained, under vigilant police supervision.

*Second.* How far may the odour of such an establishment, including cattle-yards, be detected with certainty?

*A.* The odour of establishments of this character can be detected at varying distances, dependent upon temperature, condition of atmosphere, and wind. Have recognized them in a marked degree at a distance of ten miles. The odour of the cattle-yards, under like conditions of atmosphere, temperature, and wind, have been detected at a distance of one mile.

*Third.* From what is known, can the drainage of an abattoir be safely allowed to enter a fresh-water stream flowing through a town?

*A.* Not as a general rule. It depends upon the amount of the drainage into, the quantity of water in, and the rapidity of the current of the stream. Under all circumstances it is important that this drainage should enter streams below the limits of a town or city.

*Fourth.* What effect has been observed upon property values and settlement near an abattoir?

*A.* As a necessary consequence they will diminish the value of property for residences. People generally keep at respectful distances from such establishments.

After some further discussion, the resolutions were passed.

A special committee was appointed to inquire into the causes of the increasing unsanitary condition of the watering places.

Several papers which had been sent in to the Secretary were referred to the Executive Committee for publication.

Dr. Morris read a humorous paper on the general features of this annual meeting, after which the Association adjourned *sine die*.

*Influence of Alcohol upon the Animal Economy.*—A committee of five members of the New York Neurological Society has been appointed to investigate in all its relations the influence of alcohol on the animal economy. To obtain further and more exact results, the subjects of research have been divided as follows: 1. To Dr. F. D Lente, of Cold Spring, Putnam Co., New York: The effects of alcohol upon the system in general, and upon the several organs of the body (except those of the nervous system), and its value as a therapeutical agent; 2. Dr. William A. Hammond: The effects of alcohol upon the brain and mind; 3. Dr. T. M. B. Cross: The effects of alcohol upon the spinal cord; 4. Dr. T. Edwards Clark: The effects of alcohol upon the ganglionic nervous system; 5. Dr. F. Le Roy Satterlee: The effects of alcohol upon the peripheral nervous system.

Dr. Lente has issued a circular asking answers to the following questions:—

1. Can you refer me to any clinical reports illustrating, markedly, the good or evil effects of alcohol in the treatment of disease?

2. To any facts, well authenticated, illustrating any prophylactic virtue in stimulants, especially as regards the tubercular diseases?

3. To any clinical facts bearing on the question of the value of alcoholic drinks as a *food?*

4. To any clinical facts, not contained in the ordinary treatises, illustrating its effects on the viscera, especially the stomach and liver?

5. To any facts indicating a difference in the effects of alcohol as contained in distilled or fermented drinks respectively?

6. To any facts indicating a difference in the effects of alcohol *per se*, and alcohol as it exists in brandy, whiskey, etc.?

7. What effect has it, in your experience, among your wealthier patients, or *bons vivants;* such as drink good liquors *freely* and *regularly*, but not to intoxication, for a long term of years: does it lengthen or shorten their life, or render it less or more agreeable? Please give *this* question your especial consideration, as a thoughtful answer to this is considered of especial importance. Will you indicate, if possible, very roughly, of course, what you consider the average amount of *alcohol* contained in the daily dinner drinks of these gentlemen?

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## FOREIGN INTELLIGENCE.

*Abortive Treatment of Smallpox.*—Dr. Guipon, in a communication addressed to the Académie de Médecine, states, on the strength of trials in thirty-one cases of epidemic smallpox, that the perchloride of iron exerts a great influence over the disease, lessening its duration and intensity, rendering the development of the pustules less considerable, allaying or suppressing secondary fever, and promoting a rapid convalescence. The quantities given daily varied according to age—from a minimum of twelve drops to a maximum of forty drops; and the total quantities given during the duration of the disease varied between 58 and 556 drops.—*Med. Times and Gaz.*, Oct. 31, 1874.

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*Traumatic Tetanus.*—Dr. Lannelongue, of Bordeaux, has tried intra-venous injections of chloral in a case of traumatic tetanus. The case resulted fatally.—*L' Union Médicale*, Oct. 17, 1874.

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*Fracture of the Patella.*—The Paris correspondent of the *Irish Hospital Gazette* (October 15), in a recent communication, speaks highly of M. Panas's plan of treating fracture of the patella, which is simple, and, he thinks, rational, "as it does away with all apparatus, much to the comfort of the patient, and perhaps to the saving him the expense of one, if he is obliged to find his own. M. Panas's plan is simply to place the affected limb on an inclined plane, and to keep it steady by means of a few turns of a roller, without striving to bring the broken fragments together, a measure perfectly useless, as whatever is done the surgeon can rarely expect anything more than a fibrous union, which, after all, does not much interfere with locomotion. What M. Panas studies to avoid is stiffness of the knee-joint, which so frequently follows prolonged immobility of the limb.

In another ward of the same hospital, I have seen the surgeon employ Malgaigne's hooks in fracture of the patella: a most barbarous practice, as it causes a great amount of unnecessary suffering to the patient without offering any advantage over the other plans of treatment. M. Tillaux, however, has modified this plan by applying the hooks to the India-rubber bandages he employs to bring the broken fragments together, instead of driving them into the tissues of the patient, as I have seen done elsewhere; and I remember one case in which these hooks of torture produced inflammation of the knee-joint, followed by gangrene, and the surgeon thought proper to amputate the limb to save the man's life.

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*Phlegmonous Osteo-periostitis.*—At the recent meeting at Lille of the French Association for the Advancement of Science, M. Giraldès, the well-known surgeon to the Children's Hospital, made a very valuable communication on the question of phlegmonous osteitis, the right name of which he suggested should be phlegmonous osteo-periostitis. He referred to the error which was formerly committed in connection with the disease, it being frequently mistaken for typhoid fever, and the appearance of pus being considered to be critical abscess. The important feature of the disease was tendency to suppuration and to denudation of the bone. He gave a most excellent description of the lesions, with which he made such thorough acquaintance in the wards of his hospital, and explained the surgical proceeding which he prefers in such cases. He opens the subperiostic abscess, detaches with the finger the periosteum of the diseased portion of bone, and removes all this portion up to the interepiphysal cartilage. The periosteum reproduces the bone, and with such rapidity occasionally that even on the fourth day it becomes necessary to bring together the soft parts so as to avoid osseous deformities. This proceeding he had applied with success to the tibia, humerus, lower jaw, calcaneum, etc. It could not apply to the upper part of the femur. Surgeons, he concluded, were wrong to wait for invagination of the sequestrum before operating.—*Lancet*, Sept. 26, 1874.

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*Congenital Absence of the Bladder without Incontinence of Urine.*—Dr. Fleury communicated to the Surgical Society (Paris) a very curious case of this, in a young girl who was attacked a few months only before her death with incontinence of urine, and who died from peritonitis following simple urethral catheterization. At the autopsy there was found a complete absence of the bladder, which was evidently congenital. He asks how it was that the incontinence of urine was not also congenital; a question more easily asked than answered.—*L'Union Médicale*, Oct. 31, 1874.

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*Chloral and Chloroform.*—Prof. Schiff has recently been conducting a series of experiments in his laboratory at Florence, for the purpose of determining the anæsthetic properties of chloral. Amongst other particulars, the professor has stated in a decisive manner that anæsthesia with chloroform produces dilatation of the pupils, whilst constriction is a result of anæthesia with chloral. He therefore advances this fact against the opinion which ascribes the anæsthetic action of chloral to its transformation into chloroform.—*Lancet*, Oct. 10, 1874.

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*Transfusion of Blood in the Insane.*—In the *Gazetta Medica Italiana-Lombardia* for September 19, Dr. Schivardi gives an account of several cases of insanity attended with debility and exhausting diarrhœa, in which the transfusion of lamb's blood was tried. Eight transfusions were performed on five individuals, one of these becoming, it is stated, cured, and the others ameliorated.—*Med. Times and Gaz.*, Oct. 17, 1874.

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*Mineral Oils as Disinfectants.*—Dr. John Day strongly recommends a trial of the mineral oils as disinfectants. He believes that all the mineral oils possess the property of absorbing oxygen from the atmosphere, and imparting to it increased activity by converting it into peroxide of

hydrogen, a substance possessed of very high oxidizing powers. For example, a sheet of paper, brushed over with kerosene or gasoline, yields the characteristic reaction with guaiacum resin and blood. Now, it is generally allowed that all true disinfectants are oxidizers. From his knowledge, therefore, of the oxidizing powers of gasoline, and from the fact that it is much cleaner and more volatile than kerosene, Dr. Day recommends this hydrocarbon for disinfecting purposes. He states that he has lately been using it for the purpose of disinfecting the walls, flooring, furniture, etc., of rooms in which scarlet fever patients were placed, and with most satisfactory results; but he has also had the patients freely rubbed three times a day with ethereal solution of peroxide of hydrogen and lard in the proportion of one part to eight. A trial of gasoline is further earnestly urged on the profession as a disinfectant in puerperal fever. It might be applied with a brush or sponge to any article of clothing without doing it the slightest harm; and it would not only disinfect it, but also impart to it disinfecting properties which would last for a considerable time. For among the peculiar properties of the mineral oils as disinfectants is that of their being continuous in their action. Instead of being injured or destroyed by age and exposure to atmospheric influences, as all other disinfectants are, they absolutely improve and gather force. The practitioner might also disinfect his hands by bathing them in gasoline and allowing them to dry in the open air. One caution is necessary in the use of gasoline: from its volatile and inflammable nature it should never be employed near a fire or lights.—*Med. Times and Gaz.*, Oct. 24, from *Australian Med. Journ.*, June, 1870.

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*The Surgery of the Stone Age.*—At a recent prehistoric congress at Stockholm, Dr. Prunières laid before his colleagues the results of a series of minute researches on the artificial perforations of the cranium and the cranial amulets of the neolithic period. The communication was accompanied by a numerous collection of crania, showing regular perforations of a circular form, varying from the size of half-crown to five-shilling pieces. A large quantity of circular pieces of bone were also found at the side of the skulls. All these perforations were made with flints; some on the living subject, the others *post mortem*. The first kind showed a process of cicatrization, which generally indicated a duration of several years. In one case M Broca judged from the condition of the bony plate, which was attacked by osteitis, that the patient had succumbed less than a year after operation; but this was a unique instance. The perforations were situated on different points of the cranium, on the parietal and occipital bones, the forehead, etc., which seems to exclude the idea of a religious rite. They were performed on children as well as adults, and, according to Dr. Prunières, this trephining seems to have been performed with a medical purpose, to give issue to a real or imaginary disease. The surgeons who operated with flint instruments scraped the bone layer by layer, until they came to the dura mater. On the dead body many circular pieces of bones were removed from persons who had already been trephined and cured. These pieces, instead of being scraped, have generally been sawn; and it is found that a certain number of concave pieces have been removed from the edges of the original trephining. Finally, it has been observed that fragments of bone have been replaced on the crania from which the small circles have been removed, before interment; doubtless to allow the deceased to make his appearance in a complete state in the next world. MM. Prunières and Broca believe that they can see in this practice the most ancient material proof of belief in another world. M. Prunières is disposed to believe that trephining was only performed on the insane and on epileptics—*the friends of the gods*, according to old beliefs—and that the bony fragments removed were held sacred and used as amulets.—*London Med. Record*, Oct. 21, 1874.

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*Bone Absorption by Giant-Cells.*—The "line of demarcation" in a gangrenous

limb, and the "separation of a sequestrum" in a necrosed bone, have been subjects of investigation to surgical pathologists for many a year. John Hunter himself almost completed the account of the separation of a piece of dead bone when he described the gradual deepening of the groove between it and the healthy portion, the presence of soft vascular tissue in the line of separation, and the existence of small circular hollows upon the exfoliated surface of the sequestrum, which exactly fit the granulations on the living bone. Quite recently the exact histology of this vascular layer, and of these "small circular hollows," has been investigated; and if we have not even yet been informed how absorption of bone is actually effected, we have at least been made acquainted with various steps in the process. Kölliker has been one of the principal contributors to this investigation, and his researches have been worthily followed up by Dr. Alex. Morison, of Edinburgh, who studied under him (*Pamphlet*, 1873). Kölliker showed that absorption in the normal course of the development of bone produces small cavities, and that these are filled, without exception, with giant-cells, or myeloplaques—with one, a portion of one, or several. He believed that these giant-cells arise from osteoblasts (the cells from which bone-tissue is developed), and that they are the agents by which bone (and tooth) are normally absorbed. Morison's investigations go to support this description and opinion. He has seen intermediate forms between osteoblasts and giant-cells; but he is inclined to believe that the latter may also arise by the aggregation of the nuclei of embryonic connective tissue in the spaces in the edge of bone which is being absorbed. It is possible also that the giant-cells may grow by proliferation of the connective tissue in the wall of a capillary. Whatever their origin, the presence of these peculiar cells in the line of absorption of bone seems to be now fairly established, and the idea may be entertained that their function is a destructive one. When separation is complete, they would appear to be succeeded by constructive or formative cells, which arise from embryonic connective tissue around them.—*Med. Times and Gaz.*, Sept. 19, 1874.

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*Hominal* versus *Animal Vaccination.*—Through the instigation of Dr. Guilbert, a practitioner in Paris, the Prefect of Police addressed a letter to the Academy of Medicine, requesting information as to the advisability of the revaccination of those persons who, in 1870, were vaccinated direct from the cow. This was the year in which there was such a panic in Paris, owing to a severe epidemic of smallpox, that people lost confidence in "hominal" vaccination, and gave the preference to animal vaccination. At the end of the same year and the beginning of 1871, another epidemic of smallpox broke out, and proved fatal to about 14,000 inhabitants in Paris. This was attributed by M. Guilbert to the inefficiency of animal vaccination as an antidote against smallpox; and it was on this representation of the case that the Academy was called upon to report on the subject. A committee was formed to investigate the matter, and M. Blot, the reporter, stated that inoculation from the cow, when properly performed, is at least equally as efficacious as arm-to-arm vaccination. As regards the superiority of one over the other as a preservative against smallpox, the committee could not then express an opinion; time alone could decide. The reporter, however, remarked that in either case the preservative property was only temporary. This view of the case was supported by M. Depaul. M. Guérin stated that the preservative property of hominal vaccination lasted at least fifteen years, and he asked how it was possible to know whether the immunity produced by animal vaccination lasted as long, as it was only in 1868 and 1869 that this latter mode was introduced. MM. Blot and Depaul retorted that the immunity produced by human vaccination might last ten, five, or only two years. As to the great mortality from smallpox in the epidemic of 1870 and 1871, M. Depaul had shown that, out of the 14,000 deaths, children formed a minor proportion; it was individuals of eighteen to twenty-five

or thirty, all of whom had been vaccinated with hominal lymph, that formed the largest proportion. M. Depaul concluded by stating that the accusations brought by M. Guilbert against animal vaccination were unfounded, and reiterated his opinion that animal vaccination rendered as much service as hominal. Nothing, he added, proves that children vaccinated from the cow are more liable to contract smallpox than those inoculated from arm to arm. Here the discussion ended, with MM. Depaul and Guérin and their respective partisans as far as ever from each other. *London Med. Record*, Oct. 14, 1874.

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*An Ancient Egyptian Medical Work.*—Among the printed works submitted to the Oriental Congress was a remarkable *fac-simile* exhibited before the Hamitic Section by the discoverer, Prof. Ebers, of Leipzig. This is a complete book from beginning to end, and in respect to size is only surpassed by the great Harris Papyrus in the British Museum. The manuscript in question is a perfect handbook of Egyptian medical science; and, without pretending that the physicians of our time have much to learn from their embalmed predecessors of the Nile, this papyrus may yet afford them a rich source whence may be drawn the history of their science from its earliest dawn. A calendar on the back of the MS. informs us that it was written in the sixteenth century B. C. We know already that at this remote period Egypt stood in political and commercial relation with the neighbouring States of Western Asia; but the Ebers Papyrus teaches us further that there already existed an interchange of thought and knowledge. Not only a vast number of medicaments procured from Asia are alluded to, but we find also *receipts* borrowed from a celebrated physician of the town of Byblos, in Phœnicia. Other *receipts* are derived from older writings, as, for instance, *The Book of the Wisdom of Men.* The typographical reproduction is the work of the printers Giesecke and Devrient. By a new process, the 110 pages, of which the MS. consists, are imitated with surprising fidelity. In about two months the whole work will appear, accompanied by a translation from the hand of the editor, Professor Ebers.—*Med. Record*, October 7, 1874.

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*Animals as Motor Powers.*—M. Marey has laid before the French Association for the Advancement of Science some interesting observations on the employment of animals as motor powers. He proves by means of a very elaborate instrument that the movement of animated beings as motor powers takes place by jerks, whence result shocks, and consequently a waste of labour. As an illustration of this theory, M. Marey cites the effort necessary to draw a burden behind one. If the necessary force be transmitted by means of a rigid or almost unextensible strap, for instance, of leather, the movement is jerky and more difficult than if it were transmitted by an elastic strap. It would therefore be better to attach horses to the shafts with India-rubber traces. He also gives as an illustration the manner in which boats are always dragged along the towing paths by long ropes. It would be impossible, or at least very distressing, to employ short ones. The length of the rope, which alternately tightens or slackens by slow oscillations, has in this case the same effect as India-rubber.—*London Med. Record*, Oct. 21, 1874.

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*Puerperal Mortality.*—Dr. J. Matthews Duncan, in his address in Obstetric Medicine, delivered at the recent meeting of the British Medical Association, stated his belief that in Great Britain nearly 1 in every 100 women delivered at or near full time dies in parturition, or before the puerperal state and its effects have passed over.

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*Scarlet Fever.*—A serious outbreak of this disease exists at present in London, Liverpool, Edinburgh, and some other places in Great Britain.

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Obituary Record.—Died in London, Nov. 1, 1874, aged 60, Edwin Lankester, M.D., Coroner for Middlesex. Dr. L. was well known as a lecturer on various scientific subjects, and as an author of many works on botany and food. His death was caused, it is stated, by overwork and anxiety.

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